MERCER UNIVERSITY

Flexible Employee Benefits

Program Guide

Plan Year 18/19

CORE MANAGEMENT RESOURCES

For the Plan Year Beginning July 1, 2018 and ending June 30, 2019

Mercer University

Flexible Benefits Program

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Mercer University Flexible Benefits Program

Your good health and well-being are important to Mercer University. That's why we are pleased to offer the Flexible Employee Benefits Program, designed to promote your health and personal welfare. The Program includes a wide range of plans that can help you and your family deal with many financial challenges such as:

- *The high cost of health & dental care,*
- *Loss of income due to disability,*
- *The impact on your family if you were to die or become seriously injured, and*
- *Your out-of-pocket costs for dependent care and/or medical expenses.*

Keep in mind, the benefits provided by the Flexible Employee Benefits Program are not accrued, guaranteed, or lifetime benefits. Mercer University may change or discontinue them at any time. If Program provisions described in this Summary Plan Description change, Mercer University will send you a Summary of Material Modifications (SMM) describing the changes.

Mercer University
Office of Benefits Administration

1. Introduction

MERCER UNIVERSITY has established its Flexible Benefits Plan (the "Plan") to enable Participants to elect certain non-cash benefits. The Plan is intended to qualify as a "cafeteria plan" under Section 125 of the Internal Revenue Code, which would allow non-cash benefits received pursuant to a Participant's election to be excluded from the Participant's taxable income. Although the Company and Plan Administrator will attempt to operate the Plan in a manner that it so qualifies, there are no guarantees that amounts received in the form of non-cash benefits will in fact be excludable from any Participant's income for federal and state income tax purposes or from wages for FICA purposes.

This Summary Plan Description is a brief description of the Plan and your rights, obligations, and benefits under that Plan. This Summary Plan Description is not meant to interpret, extend, or change the provisions of the plan in any way. The provisions of the Plan may only be determined accurately by reading the actual Plan document. A copy of the Plan is on file at your Employer's office and may be read by you at any reasonable time. If you have any questions regarding the Plan, or this Summary Plan Description, you should ask the Plan Administrator. In the event of any discrepancy between this Summary Plan Description and the actual provisions of the Plan, the Plan will govern.

2. General Information about the Plan

There is certain general information that you may need to know about the Plan. This information has been summarized for you in this section.

MERCER UNIVERSITY Flexible Benefits Plan is the name of the Plan. The provisions of the Plan became effective on April 1, 1994, which is called the Effective Date of the Plan. The Plan's records are maintained on a twelve-month period of time. This is known as the Plan Year. The Plan Year begins on July 1 and ends on June 30.

Your Employer's name, address and identification number are:

MERCER UNIVERSITY
1501 Mercer University Drive
Macon, Georgia 31207
478-752-2388
TAX ID # 58-0566167

The name, address, and business telephone number of the Plan's Administrator are same as Employer

The Plan's Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Administrator has the discretionary authority to construe the terms of the Plan and make determinations on questions that may affect your eligibility for benefits. The Plan Administrator will also answer any questions you may have about the Plan.

3. Operation of the Plan

A. Participation in the Plan

You are eligible to become a Participant in the Plan if you customarily work at least 30 hours per week for the Employer. If you meet this requirement, you may become a Participant by completing and returning to the Plan Administrator one or more forms on which you elect to receive the specified non-cash benefits and agree to reduce your compensation by the cost of such benefits. After your properly completed election forms are received by the Plan Administrator, your cash compensation will be reduced and such reduction will be used to purchase non-cash benefits for you in accordance with such election forms.

B. Available Benefits

The benefits that may be elected under the Plan are cancer insurance, dental insurance, dependent care assistance, medical care expense reimbursement, disability insurance, life insurance, and medical insurance. With the exception of dependent care assistance and the medical care expense reimbursement plan; all of the benefits under the plan will be provided through policies issued by insurance companies. Amounts elected by you to be applied toward such benefits will simply be paid to the appropriate insurance company.

The Employer will set up an account to reflect amounts by which your compensation is reduced to cover dependent care assistance. You will be entitled to claim reimbursements from such account for qualified dependent care expenses incurred by you, if you satisfy all substantiation and other requirements prescribed in the dependent care election and claim forms to be provided to you by the Administrator. To the extent permitted by law, amounts reflected in your dependent care assistance account will be held in a separate fund, and all reimbursements will be made from the assets of that account.

Amounts added to your account during any Plan Year may be used to reimburse dependent care expenses incurred only during that Plan Year. Amounts in your account in excess of incurred expenses during any Plan Year will be forfeited.

C. Change or Revocation of Election

You will be given the opportunity to change or revoke your election to receive benefits prior to the beginning of any Plan Year by filing new election forms. Your failure to file such new election forms shall be deemed an election not to receive dependent care assistance for such Plan Year and an election to continue to receive all other benefits in the same amounts as were received in the previous Plan Year.

Any election of benefits that you make (or fail to make) generally will be effective for the entire Plan Year and cannot be changed or revoked until the beginning of the following Plan Year. A change or revocation may be allowed to take effect during a Plan Year, however, if it results from and is consistent with a "change in family status" as defined in the election form.

4. Claims for Benefits

You will be provided forms on which to claim reimbursement for qualified dependent care and medical care expenses incurred by you. When you file those forms, you will be required to provide invoices or other documents substantiating your claim to these benefits. The Administrator of the Dependent Care Assistance Plan and the Medical Care Reimbursement will review your claim form and direct that the claimed benefits be paid to you if the Administrator believes such payment to be proper. If the Administrator does not believe your claim to benefits to be complete or valid, you will receive notice of this determination in writing.

The Dependent Care Assistance Plan and Medical Care Expense Reimbursement provides procedures under which you will be able to present any needed information or documentation or obtain review of a denial of your claim.

Because benefits other than dependent care assistance and medical care assistance reimbursement are provided through policies issued by insurance companies, the claims procedures provided in the appropriate policy will apply to such benefits.

5. Explanation of Your ERISA Rights

As a participant in this Plan you are entitled to certain rights and protections under the Employer Retirement Income Security Act of 1974, also called ERISA. ERISA provides that all Plan participants will be entitled to:

a. Examine, without charge, all Plan documents, including:
    1. insurance contracts;
    2. collective bargaining agreements;

3. And copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

This examination may take place at the Administrator's office and at other specified employment locations of the Employer.

b. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies;
c. Receive a summary of the Plan's annual financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Administrator review and reconsider your claim. (See the Article in this Summary entitled "Claims for Benefits”.)

Under ERISA, there are many steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $100.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in any state or federal court. If the Plan's fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and a fee if, for example, it finds your claim is frivolous.

If you have any questions about this statement, or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Labor-Management Services Administration, Department of Labor.

6. Amendment and Termination

Your Employer has the right to amend or terminate the Plan at any time.

Flexible Benefits Program Summary of Benefits

Conditional Understanding: This document is intended to be a summary document only and is not intended to limit, enhance or supersede the provisions of Mercer University's policies, procedures and contracts which are in place and are the controlling authorities over the benefits summarized herein. Mercer reserves the right to change or eliminate any of these benefits at its discretion.

Note: For purposes of this document:

The term "Regular Full-time Employee" includes all employees (Faculty, Staff, Visiting Faculty, and Full-time Residents) hired to work a minimum of 30 hours per week on an on-going basis.

The term "Regular Part-time Employee" includes all employees who work at least 20 hours per week, but less than 30 hours per week on a regular basis, for a total of at least 1,000 hours or more in a year.

The term "Temporary or Seasonal Employee" includes all employees hired to work temporarily, only part of the time during the year following their first day of employment. Unlike "Regular Fulltime" and "Regular Part-time" these employees are hired only for a short time (usually less than six months) as additional staffing becomes necessary for special programs or events. "Temporary or Seasonal Employees" whether full-time or part-time, are not considered eligible for benefits under this plan.

The term "Classified Employee" includes all employees whose positions are included in the University's Classification system. In general, these are all Full-Time and Part-Time Regular employees except Faculty, Executives, and employees in certain Administrative and Professional positions.

The Employee portion of the Premium Payments of the Benefits described in this Summary may be paid through Salary Deduction with Pre-Tax or After Tax Dollars. All Premiums contained in this Summary are subject to change and should be verified through the University's Benefits Office for current accuracy.

Medical Schedule of Benefits

Available to: Regular Full-Time Employees

The Mercer Health Plan is a self-insured plan that does not restrict participants to utilizing any specific physicians or hospitals; you may choose your own health providers. You receive the highest level of benefits when utilizing a Patient First Provider in Georgia or when you travel outside Georgia using First Health Provider. No risk assessment or compliance required. Standard benefit levels applicable to eligible procedures, charges and prescriptions as set forth in Plan Payment Provisions and Prescription Drug Card Benefits Co-Pay sections.

Accident Expense*

1. Treatment must be obtained within 14 (including the day of the accident) days of accident;
2. Outpatient treatment is paid at 100%, *waiving the deductible;
3. Charges incurred for Accident Expenses after the first 14 days are payable at 80% In Network and 60% Out-Of-Network, after the deductible has been met.

Only injuries sustained as the direct result of non-occupational accident are covered under This Plan.

Calendar Year Deductible In-Network:
$600 per Covered Participant

Out-of-Network:
$1,200 per Covered Participant

Calendar Year Maximum Benefit Unlimited
per Covered Person

Calendar Year Out-of-Pocket Maximum
(includes deductible, maximum of 3 per family unit)

In-Network:	**Out-of-Network:**
$3,500 per Covered Participant	Unlimited

Chemical Dependency / Alcoholism / Mental / Nervous Conditions
Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit

Refer to *Plan Payment Provisions* for detailed covered expenses.

Chiropractic Care
The maximum annual benefit payable per Covered Person is $2,000.

Claims Are Paid Based On
Medical Necessity of the services being provided and of Reasonable Charges

Claims are Processed & Paid By
Core Administrative Services, Inc. (CAS)
(478) 741-3521 or 1-888-741-CORE

Coinsurance
The Coinsurance for This Plan is as follows:
In-Network – 80% after applicable deductible is satisfied.

Out-of-Network – 60% after applicable deductible is satisfied.

Convalescent Care Facility

Maximum sixty (60) days per Calendar Year. *(Additional days must be approved by the Medical Director prior to the 60 days expires.)*

Refer to *Plan Payment Provisions* for detailed covered expenses.

Covered Medical Services

Services Medically Necessary for inpatient and outpatient care and treatment of a covered illness or injury, to include physician, hospital, lab, radiology, etc.

Dialysis Treatment – Outpatient (In-Network and Out-of-Network)

00100% of the Reasonable Charge after all applicable deductibles and coinsurance

Refer to *Plan Payment Provisions* for detailed covered expenses.

Educational Services, Diabetes

Up to three (3), one-hour sessions will be covered at 100% per lifetime.

Effective Date of Coverage

1st Day of Month Following Date of Hire or Eligibility

Emergency Room Services

Non-Accident, Non-Emergency Services have a $25 up-front fee, which will be waived if admitted. Additional charges are subject to the Deductible and applicable Coinsurance.

Flu Vaccinations

Annual flu vaccines will be covered by the University at no cost to the Faculty and Staff members. Family members will be charged a reduced fee at their own expense. The vaccines are to be administered by Mercer Health Systems on the Macon campus and Campus Health Care on the Atlanta campus.

Home Health Care

Each visit by a nurse or therapist will be considered one visit and four hours of home health side services will be considered one visit. Your plan has a maximum limit of one-hundred twenty (120) visits per Calendar Year.

Refer to *Plan Payment Provisions* for detailed covered expenses.

Hospice Care

Refer to *Plan Payment Provisions* for detailed covered expenses.

Lifetime Maximum Benefit *There is no Lifetime Maximum.*

Unless otherwise noted under a specific area, all benefits are subject to the Lifetime Maximum Benefit.

Maternity Expenses

Maternity Benefits are available for all Covered Female Participants.

Network

The Networks for This Plan are: Patient First Network (Inside GA)
First Health Network (Outside GA)

Patient First Prescription Drug Benefit Co-Pays

RETAIL PHARMACY COSTS PER PRESCRIPTION **Is the greater of 20% or the flat rate co-pay below**			
Day Supply	30 DAYS	60 DAYS	90 DAYS
Generic Drugs	$20	$40	$60
Brand Name Drug is selected with NO Generic Available	$35	$70	$105
Brand Name Drug is selected with Generic Available	$60	$120	$180
Total costs not to exceed $150 for any 30-day supply			

MAIL ORDER COSTS PER 90-DAY PRESCRIPTION **Is the greater of 20% or the flat rate co-pay below**	
90 day supply available through mail order for two co-pays	
Day Supply	90 days
Generic Drugs	$40 *
Brand Name Drugs (No Generic Available)	$70 *
Brand Name (By Preference)	$120 *
Total costs not to exceed $300 for any 90-day supply	

Pre-Certification Authority

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

Physician/Specialist Co-Pay

There is NOT a flat Physician/Specialists Co-Pay for this Plan/ instead, the patient will be responsible for 20% of the bill when using an In-Network Physician and 40% when using an Out-of-Network Physician after the deductible has been met.

Refer to *Plan Payment Provisions* for detailed covered expenses.

Podiatry

Custom Shoes are limited to one pair (up to $200) per Calendar Year.

Psychiatric Benefits

Mental/Nervous Conditions

Inpatient: Payable as any other benefit

Outpatient: Payable as any other benefit

Chemical Dependency/Alcoholism

Inpatient: Payable as any other benefit

Outpatient: Payable as any other benefit

Routine Physical Exams, In-Network*

Routine Annual Exams performed by network providers are paid at 100% for the first $300 in charges. The balance is paid at 80% since deductibles are waived. The tests included with this benefit are routine pap smears, prostate exams, and routine lipid profiles. Routine Mammograms are paid at 100%, deductible waived. All out-of-network services will be paid at 60% after calendar year deductibles have been met.

Routine Well Baby Care (RWBC)

(In-Network RWBC)

The following benefits, which are available for all persons under one year of age, are covered under the Plan when an in-network provider performs services. You must participate in Mercer's group health plan to receive this benefit.

The Well Baby Care Benefit includes routine office visits accompanied by standardized immunizations at a Healthcare Facility In-Network. (*Costs associated with treatment of sickness, injury, or diseases and immunizations required solely for foreign travel are excluded from this benefit.*)

1. The First $400 is paid at 100%, waiving the Deductible;
2. Charges incurred for Routine Well Baby Care in excess of $400 are payable at 80%, waiving the Deductible.
3. This benefit is available to all covered Participants under age one.

For Children over one year of age, refer to *Routine Physical Exams*.

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

See also *Newborn Expenses*.

Health Plan Monthly Employee Premium Costs:

	Salary Under $50k*	Salary Between $50k & $100k	Salary Over $100k
Employee Only	$94	$104	$114
Employee + One Child	$247	$264	$280
Employee +Spouse	$301	$315	$327
Employee +Family	$415	$435	$454

Employees who qualify for the IRS Earned Income Credit are encouraged to contact the Benefits Office as special rates may apply.

Dental Schedule of Benefits

Available to: Regular Full-Time Employees.
The Mercer Dental Plan is a self-insured plan, which does not restrict participants to utilizing any specific dentists or facilities; you may choose your own dental providers. **There is a one-year wait provision for Major Restorative Services (bridges, crowns, partials, etc.) and Orthodontic Services.**

Basic Services
Eligible charges are subject to Calendar Year individual deductible; balance then payable at 80% of the next $750, and 50% of the next $1,200 in charges. Please refer to Dental Plan Payment Provisions for more details.

Calendar Year Deductible
Individual Deductible $75 for ALL services
Family Deductible $225 for ALL services

Calendar Year Benefit Maximum
The Calendar Year Maximum Benefit under this Plan is $1,200 per Covered Person. This is the total amount payable for covered dental services (not including Orthodontic Benefit) incurred by a Covered Person during the Calendar Year.

Claims Are Paid Based On
Medical Necessity of the Services Being Provided

Coinsurance

The Coinsurance for This Plan per Calendar Year is as follows:
80% of the next $750
50% of the next $1,200

Dental Provider

Any Dentist licensed to practice

Effective Date of Coverage

1st Day of Month Following Date of Hire or Eligibility

Five Year Rule

Charges for replacing an appliance or prosthetic device, such as a denture, crown or bridge will not be covered unless it is at least five (5) years old or cannot be made usable.

Major Services

No Major Services will be covered under This Plan for the first twelve (12) months of Coverage.

Eligible charges are subject to Calendar Year individual deductible, balance then payable at 80% of the next $750, and 50% of the next $1,200 in charges. Please refer to Dental Plan Payment Provisions for more details.

Orthodontic Benefits

Eligible charges are subject to Calendar Year individual deductible, balance then payable at 50%. Orthodontic payments have a Lifetime Maximum benefit of $1,000 per covered person.

Sealants

Application of Sealants (Limited to Children under age 14)

Teeth Lost Before Covered Under This Plan

There are no benefits for a prosthetic devise which replaces teeth lost before becoming covered under this Plan, unless the devise also replaces one or more natural teeth lost or extracted after the Covered Person became covered under this Plan.

Your Monthly Cost

Employee Only	$28
Employee + 1	$50
Employee + 2	$72
Employee + 3 or more	$94

Life Insurance

Available to: Regular Full-Time Employees

Basic Life Insurance

Mercer University provides Basic Term Life Insurance for all full time employees

Effective Date of Coverage

1st Day of Month Following Date of Hire or Eligibility

Employee Life Insurance Coverage

Equivalent to employee's annual salary up to a maximum of $50,000

Monthly Cost

This premium is fully paid by the University

Supplemental Life Insurance

Mercer employees may purchase Supplemental Life Insurance through payroll deduction

Effective Date of Coverage

1st Day of Month Following Date of Hire or Eligibility

Supplemental Life Insurance Coverage

$10,000 increments up to 2 times employee's annual salary

Monthly Cost

Based on age rated schedule

Basic Dependent Life Insurance

Mercer employees may purchase Life Insurance to insure dependents

Effective Date of Coverage

1st day of month following date of hire or eligibility

Basic Dependent Life Insurance Coverage

Spouse: $10,000

Children: 10 days to 6 months - $1,000

6 months to age 23 - $10,000

(Up to age 25 if full-time student)

Monthly Cost

$2.66 per Family

Maximum benefit is 50% of the employee's Basic Life Insurance.

Supplemental Dependent Life Insurance Coverage

Employees may purchase additional "Dependent Optional Life Insurance" through payroll deduction in increments of $5,000 for spousal coverage (Not to exceed 50% of the employee's optional life insurance up to a max of $150,000) Additional life insurance may be purchased for dependent children in increments of $2,500 up to a max of $10,000. Rates vary based on age. *Dependent Life Insurance does not reduce the taxable gross.*

Cancer Insurance

Available to Regular Full-Time Employees

Mercer offers the option of purchasing a Cancer Insurance Policy to offer you and your family supplemental protection in the event you are diagnosed with Cancer, including Leukemia & Hodgkin's Disease. Coverage is provided through American Family Life Assurance Company of Columbus (AFLAC).

Effective Date of Coverage

1st Day of Month Following Date of Approval by AFLAC

Benefits Include

Please refer to the Outline of Coverage as provided by the Benefits Office.
Benefits are Paid Directly to Policyholder, unless assigned.

Monthly rates vary based on age and when grandfathered, the date the policy was purchased

Employee Only
One Parent Family (Employee and child)
Two Parent Family (Employee, spouse and/or children)

Long Term Disability Insurance

Available to Regular Full-Time Employees

Mercer provides Long Term Disability coverage for benefit eligible faculty and staff which will provide you income should you become disabled. Generally, the policy pays a monthly income benefit equal to 60% of your monthly wage base, less the sum of benefits from any other income sources, during your period of disability. Coverage is provided through The Standard Insurance Company.

Effective Date of Coverage

1st Day of Month after 1 Year of continuous Service
Some Waivers Apply

Disability Benefits Start

1st Day of Month after 6 Months of continuous Disability

Your Monthly Cost

Mercer pays 100% of Premium

Employee Assistance Program (EAP)

This service is offered to regular full-time employees who have completed one year of continuous full-time service.

The EAP is a service fully paid for by the University that provides short-term counseling to full time faculty, staff, and their families who are facing stressful situations, emotional difficulties, family problems, marital concerns, substance abuse, financial troubles, or other similar challenges.

The counseling provided through EAP is completely confidential; reports are not made to the University to identify who has accessed this service. The utilization of the EAP holds the same level of confidentiality and protection as when seeing any other medical professional. Information will be released only with written permission or as required by law.

The EAP is always available through telephone consultation and online access. The toll-free number is 888-293-6948 or log onto www.eapbda.com. Enter standard as the login ID (in all lower case letters) and eap4u as the password (in all lower case letters).

The program also includes up to three face-to-face assessment and counseling sessions. If an extended period of counseling is needed, the EAP counselor will help make a referral to a physician, psychologist, lawyer, or whatever professional would best meet the needs. If the sources of the problem is emotional, mental or a medical situation, and if the individual is covered under the terms of the Mercer Health Plan, extended counseling will be covered under the Mercer Health Plan.

*This program is offered in connection with group Long Term Disability insurance policies underwritten by Standard Insurance Company.

Dependent/Child Care Assistance

Available to Regular Full-Time Employees

Mercer offers the option of depositing funds into a Pre-Tax Account for the purpose of paying for services to have your dependent children cared for so that you can work. The services may be provided by a child day care center or at home day care so long as you are paying someone to take care of your children while you are at work. This also applies to the day care of elderly parents if they are dependent upon you for care. Funds withheld from your salary into this account will not be subject to State, Federal or Social Security Taxes and must be used during the fiscal year in which they are withheld or they will be forfeited.

Effective Date of Eligibility **Annual Maximum Deferrals** Effective Immediately Married: $5,000 per Year

Single: $2,500 per Year

Your Monthly Cost

The Amount you elect to Defer. Participant must enroll each year.

Medical Care Expense Reimbursement

Available to Regular Full-Time Employees

Mercer offers the option of depositing funds into a Pre-Tax Account for the purpose of paying for medical expenses not covered by insurance, such as your Medical and Dental Deductibles, Copayments, disallowed charges, etc. Funds withheld from your salary into this account will not be subject to State, Federal, or Social Security Taxes and must be used during the fiscal year in which they are withheld.

Effective Date of Eligibility

1st Day of Month after completion of 3 Months of Service

Annual Maximum Deferrals

$2,650 per Year

Your Monthly Cost

The Amount you elect to Defer. Participant must enroll each year.

Mercer Health Plan
Summary Plan Description

Name of the Plan:	The Corporation of Mercer University Employee Benefit Health Care Plan
Type of Plan:	Self-Insured Welfare Plan providing health, prescription and dental benefits.
Type of Administration:	Contract Administration with the Third Party Administrator.
Address of the Plan:	1501 Mercer University Drive, Macon, GA 31207
Plan Number:	100010A Medical and 100010A Dental
Group Number:	010-01W
Plan Sponsor:	The Corporation of Mercer University, Inc.
Federal Tax ID#:	58-0566167
Plan Effective Date:	January 1, 1995
Plan Renewal Date:	July 1st
Plan Fiscal Year Ends:	June 30th
Third Party Administrator:	Core Administrative Services PO Box 90 Macon, GA 31202-0090 (478) 741-3521 (888) 741-2673
Named Fiduciary:	The Corporation of Mercer University, Inc.
Agent for Service of Legal Process:	The Corporation of Mercer University, Inc.
Waiting Period:	None
Effective Date of Coverage:	First of the month following the waiting period.
Termination Date of Coverage:	Last day of the month termination is effective, unless the employee has worked less than ½ of the month. Health and dental benefits will continue through the date that premiums have been remitted. Employee must request to stop coverage by completing a Change in Family Status Form if terminating after the 15th of each month.
Contributions:	Both Employer and the Employee contribute towards coverage. Specific employee rates may be obtained from the Benefits Administrator or CAS.

Grandfathered Health Plan

Mercer University believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at:

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

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Introduction

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

The Plan Sponsor assumes the sole responsibility for funding the employee benefits out of general assets. The Plan is intended to comply and be governed by the "Employee Retirement Income Security Act of 1974" as amended (ERISA) and not state law. Therefore, state law governing guarantee funds may not cover benefits payable under the Plan if the Plan Sponsor is unable to pay benefits. The Plan Sponsor has purchased excess risk insurance coverage which is intended to reimburse the Plan Sponsor for certain losses incurred and paid under the Plan by the Plan Sponsor. The excess risk insurance coverage is not a part of the Plan.

This booklet, the Group Provisions Pages, and any amendments constitute the Plan Document for the Employer's benefit plan. This Plan is maintained for the exclusive benefit of the employees and each employee's rights under this Plan are legally enforceable. The Employer has the right to amend the Plan 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. Requests for exceptions to the Plan must be submitted in writing to the Plan Administrator prior to receiving the service and/or supply.

The following pages of this booklet include: the requirements for being covered under This Plan, the provisions concerning termination of coverage, a description of the Plan 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 Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relative to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Reasonable. Benefits under this Plan shall be paid only if the Plan 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 Plan and they are listed in the Plan Payment Provision or Definitions section. When reading the provisions of the Plan, 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. Benefits are not contractually guaranteed.[1]

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, the Employer 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 Employer signed Plan 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)

EMPLOYEE HEALTH CARE PLAN
OF
MERCER UNIVERSITY

Adoption Agreement and Elections

ARTICLE I

Section 1.01 The undersigned Employer hereby makes the elections below and adopts this Employee Health Care Plan for the benefit of employees of the Employer. This Plan is intended to qualify as an employees' health care plan and a group health plan under Sections 105 and 162 of the Internal Revenue Code of 1986 ("Code"), as amended, and the Regulations thereunder.

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

Section 1.03 Election Regarding Preferred Provider Agreement.

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

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

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

1. Patient First Network (P1N)
2. First Health Network (Outside of Georgia)

Signature _____

Title _____ Date _____

Comprehensive Medical Expense Benefit

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

1. Medically Necessary;
2. Prescribed by or given by a Physician;
3. Reasonable Charges (when no Network is in place, except as provided by the outpatient dialysis provision, 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 Plan Payment Provisions.

Medical Schedule of Benefits

Available to: Regular Full-Time Employees

The Mercer Health Plan is a self-insured plan that does not restrict participants to utilizing any specific physicians or hospitals; you may choose your own health providers. You receive the highest level of benefits when utilizing a Patient First Provider in Georgia or when you travel outside Georgia using First Health Provider. No risk assessment or compliance required. Standard benefit levels applicable to eligible procedures, charges and prescriptions as set forth in Plan Payment Provisions and Prescription Drug Card Benefits Co-Pay sections.

Accident Expense*

1. Treatment must be obtained within 14 (including the day of the accident) days of accident;
2. Outpatient treatment is paid at 100%, *waiving the deductible;
3. Charges incurred for Accident Expenses after the first 14 days are payable at 80% In Network and 60% Out-Of-Network, after the deductible has been met.

Only injuries sustained as the direct result of non-occupational accident are covered under This Plan.

Calendar Year Deductible In-Network:
$600 per Covered Participant

Out-of-Network:
$1,200 per Covered Participant

Calendar Year Maximum Benefit Unlimited
per Covered Person

Calendar Year Maximum Payable Unlimited
per Covered Person

Calendar Year Out-of-Pocket Maximum – (includes deductible, maximum of 3 per family unit) In-Network:
$3,500 per Covered Participant

Out-of-Network: Unlimited
Chemical Dependency / Alcoholism / Mental / Nervous Conditions
Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit

Refer to *Plan Payment Provisions* for detailed covered expenses.

Chiropractic Care
The maximum annual benefit payable per Covered Person is $2,000.

Refer to *Plan Payment Provisions* for detailed covered expenses.

Claims Are Paid Based On
Medical Necessity of the services being provided and of Reasonable Charges

Claims are Processed & Paid By
Core Administrative Services, Inc. (CAS)
(478) 741-3521 or 1-888-741-CORE

Coinsurance
The Coinsurance for This Plan is as follows:
In-Network – 80% after applicable deductible is satisfied.
Out-of-Network – 60% after applicable deductible is satisfied.

Convalescent Care Facility
Maximum sixty (60) days per Calendar Year. *(Additional days must be approved by the Medical Director prior to the 60 days expires.)*

Refer to *Plan Payment Provisions* for detailed covered expenses.

Covered Medical Services
Services Medically Necessary for inpatient and outpatient care and treatment of a covered illness or injury, to include physician, hospital, lab, radiology, etc.

Educational Services, Diabetes

Up to three (3), one-hour sessions will be covered at 100% per lifetime.

Effective Date of Coverage

1st Day of Month Following Date of Hire or Eligibility

Emergency Room Services

Non-Accident, Non-Emergency Services have a $25 up-front fee, which will be waived if admitted. Additional charges are subject to the Deductible and applicable Coinsurance.

For Accident Related Services see *Accident Expense.* See also *Urgent Care Facility*.

Employee Eligibility

The term "Regular Full-time Employee" includes all employees (Faculty, Staff, Visiting Faculty, and Full-time Residents) hired to work a minimum of 30 hours per week on an on-going basis.

The term “Regular Part-time Employee” includes all employees who work at least 20 hours per week, but less than 30 hours per week on a regular basis, for a total of at least 1,000 hours or more in a year.

The term "Temporary or Seasonal Employee" includes all employees hired to work temporarily, only part of the time during the year following their first day of employment. Unlike "Regular Full-time" and "Regular Part-time" these employees are hired only for a short time (usually less than six months) as additional staffing becomes necessary for special programs or events. "Temporary or Seasonal Employees" whether full-time or part-time, are not considered eligible for benefits under this plan.

The term “Classified Employee” includes all employees whose positions are included in the University’s Classification system. In general, these are all Full-Time and Part-Time Regular employees except Faculty, Executives, and employees in certain Administrative and Professional positions.

The Employee portion of the Premium Payments of the Benefits described in this Summary may be paid through Salary Deduction with Pre-Tax or After Tax Dollars. All Premiums contained in this Summary are subject to change and should be verified through the University’s Benefits Office for current accuracy.

Flu Vaccinations

Annual flu vaccines will be covered by the University at no cost to the Faculty and Staff members. Family members will be charged a reduced fee at their own expense. The vaccines are to be administered by Mercer Health Systems on the Macon campus and Campus Health Care on the Atlanta campus.

Home Health Care

Each visit by a nurse or therapist will be considered one visit and four hours of home health side services will be considered one visit. Your plan has a maximum limit of one-hundred twenty (120) visits per Calendar Year. If you live in a rural area which does not have a nearby home health care agency, private duty nursing services for up to 60 days per calendar Year may be covered; however, there is a maximum allowance of $75 per twenty-four (24) hour period (subject to all other conditions and limitations).

Please call one of the nurse case managers at CHS (478-741-3521 or 888-741-CORE) for assistance in making home health care arrangements. If there are no In-Network Home Care Agencies, there is no penalty for going Out-of-Network.

Refer to *Plan Payment Provisions* for detailed covered expenses.

Hospice Care

Hospice Benefits have a maximum lifetime benefit of $20,000.

Refer to *Plan Payment Provisions* for detailed covered expenses.

Lifetime Maximum Benefit *There is no Lifetime Maximum.*

Unless otherwise noted under a specific area, all benefits are subject to the Lifetime Maximum Benefit.

Maternity Expenses

Maternity Benefits are available for all Covered Female Participants.

Network

The Networks for This Plan are: Patient
First Network (Inside GA)
First Health Network (Outside GA)

Patient First Prescription Drug Benefit Co-Pays

There is not an additional deductible for prescription drugs. Refer to Patient First Prescription Drug Expense Benefits and Prescription Drug Coverage Provisions for detailed covered expenses.

If the actual cost of the Prescription Drug is less than the co-pay, the Covered Person will be responsible only for the actual cost. NO “Coordination of Benefits” will apply for Prescription Drug Coverage whether retail or mail order.

Benefits are payable when a Covered Person incurs eligible drug expenses which are in excess of the co-payment 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 Patient First system. The covered person must show the Patient First ID card in order to obtain the appropriate co-pay.

Co-Payment or the Greater of 20% per Prescription:

RETAIL PHARMACY Co-Payment is the Greater of 20% per Prescription or the flat rate below:			
Day Supply	30 days	60 days	90 days
Generic Drugs	$20	$40	$60
Brand Name Drugs (No Generic Available)	$35	$70	$105
Brand Name (By Preference)	$60	$120	$180
Total costs not to exceed $150 for any 30-day supply			

Prescription Mail Order Program

The mail service prescription drug program is an extension of the prescription drug benefit that allows you to receive a 90-day supply of medications at the costs of 60 days. Some medications, however, may not be available through the mail order program. In the event that your prescription may not be dispensed through mail order, retail co-pays will apply.

Mail Order Co-Payment or the Greater of 20% per Prescription:	
90 day supply available through mail order for two co-pays	
Day Supply	90
Generic Drugs	$40
Brand Name Drugs (No Generic Available)	$70
Brand Name (By Preference)	$120
Total costs not to exceed $300 for any 90-day supply	

Physician/Specialist Co-Pay

There is NOT a flat Physician/Specialists Co-Pay for this Plan/ instead, the patient will be responsible for 20% of the bill when using an In-Network Physician and 40% when using an Out-of-Network Physician after the deductible has been met. *Refer to Plan Payment Provisions for detailed covered expenses.*

Podiatry Custom Shoes are limited to one pair (up to $200) per Calendar Year.

Pre-Certification Authority

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

Psychiatric Benefits

Mental/Nervous Conditions
Inpatient: Payable as any other benefit
Outpatient: Payable as any other benefit
Chemical Dependency/Alcoholism
Inpatient: Payable as any other benefit Outpatient: Payable as any other benefit

Routine Physical Exams, In-Network*
The following benefits, which are available for all persons over age one covered under the Plan when an in-network provider performs services. You must participate in Mercer's group health plan to receive this benefit.
The Routine Annual Exam Benefit includes the office visit along accompanied by any of the following tests administered at a Healthcare Facility In-Network. Tests included when prescribed in conjunction with the routine annual exam are, pap smears, prostate exams, and/or immunizations when administered at a registered healthcare facility)

1. The First $300 is paid at 100%, waiving the Deductible;
2. Charges incurred for Routine Physical Exams in excess of $300 are payable at 80%, waiving the Deductible.
3. This benefit is available to all covered Participants over age one.

Routine Mammograms are paid at 100%, waiving the Deductible
Immunizations required solely for foreign travel are NOT COVERED. For Vision and Hearing services, refer to those sections. They are not considered a part of this benefit.

Routine Physical Exams, Out-Of-Network*
The following benefits that are available for all persons over age one covered under this Plan when services are performed by an out of network provider (In-Network providers are paid as per the prior description). You must participate in Mercer's group health plan to receive this benefit.
Annual exams to include:

1. Mammogram,
2. Pap smear and the lab and office visit charges associated with it, and
3. Prostate exam and the office visit charges associated with it, and
4. Immunizations when recommended by a licensed Physician and administered at a registered Healthcare facility.

All Charges are subject to the Deductible, and then payable at 60%. Immunizations required solely for foreign travel are NOT COVERED. For Vision and Hearing services, refer to those sections. They are not considered a part of this benefit.

Routine Well Baby Care (In-Network)
The following benefits, which are available for all persons under one year of age, are covered under the Plan when an in-network provider performs services. You must participate in Mercer's group health plan to receive this benefit.
The Well Baby Care Benefit includes routine office visits accompanied by standardized immunizations at a Healthcare Facility In-Network. (*Costs associated with treatment of sickness, injury, or diseases and immunizations required solely for foreign travel are excluded from this benefit.*)

1. The First $400 is paid at 100%, waiving the Deductible;
2. Charges incurred for Routine Well Baby Care in excess of $400 are payable at 80%, waiving the Deductible.

3. This benefit is available to all covered Participants under age one.

For Children over one year of age, refer to *Routine Physical Exams*. See also *Newborn Expenses*.

Routine Well Baby Care (Out-of-Network)

All Charges are subject to the Deductible, and then payable at 60%.
See also *Newborn Expenses*.

Medical Plan Payment Provisions

This Plan will pay the percentages allowed, based on Reasonable charges when no network is in place or services are rendered Out-of-Network, once the deductible has been met unless otherwise marked by an asterisk (*) which means the deductible is waived.

Abortion

Elective

This is NOT a Covered Expense under This Plan.

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 Plan.

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

Accident Expense*

Injuries sustained as the direct result of a non-occupational accident.

1. Treatment must be obtained within 14 (including the day of the accident) days of accident;
2. Outpatient treatment is paid at 100%, *waiving the deductible;
3. Charges incurred for Accident Expenses after the first 14 days are payable at 80% In Network and 60% Out-of-Network, after the deductible has been met.

Only injuries sustained as the direct result of non-occupational accident are covered under This Plan.

Acupuncture

This is NOT a Covered Expense under This Plan.

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

Alcoholism

See *Chemical Dependency / Alcoholism*.

Allergy Testing

Allergy testing is used to determine the specific substances that cause an allergic reaction in an individual. It may be used to determine if a group of symptoms is a true allergic reaction.

Ambulance

Air

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 is a covered expense with conditions of limitation. 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 Plan Administrator. *There is a cap limit of allowable charges under this plan based on industry standard and set by Contact Core Management Resources.*

Ground

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

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

Anesthetics and their professional administration when ordered by the Attending Physician in connection with a Covered Procedure.

Anorexia

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 Plan.

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 Plan.

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

When an assistant surgeon is required to render technical assistance during an operation, the eligible expense for such services shall not exceed 25% of reasonable charges for the primary surgeon’s fees.

Behavioral Modification

See specific treatment, therapy or program.

Birth Control, Prescriptions

See *Prescription Drug Coverage*.

Birth Control, Procedure

Any device or procedure that requires a prescription or fitting by a Physician. See also *Prescription Drug Coverage* and *Sterilization*.

Blood and Blood Derivatives

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

An eating disorder involving repeated and secretive episodic bouts of binge eating followed by self-induced vomiting, use of laxatives or diuretics, or fasting.

Calendar Year Deductible

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

Calendar Year Out-of-Pocket Maximum

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

For limitations, see specific Plan Payment Provision.

Cataract Surgery, Eye Wear Afterwards

The Plan covers the cost of Cataract Eye Surgery and implantation of an Intraocular Lens. Coverage for Intraocular Lens is limited to the cost of a single vision lens. The Initial purchase of contact lenses or eyeglasses (but not both) if required as a result of Cataract Surgery is covered. In lieu of contact lenses or glasses, the plan will allow an additional $500 coverage (subject to deductible & coinsurance) towards the separate expense of a multi-focal lens (i.e., ReSTOR, Toric Lens, etc…)

Chemical Dependency / Alcoholism

For the purposes of This Plan, Chemical Dependency / Alcoholism treatment means the use of any or all of the following therapeutic techniques, as used in a treatment plan 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 plan.

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

Treatment of disease by means of chemical substances or drugs. See also *Prescription Drug Coverage*.

Chiropractic Care

The services of a licensed Chiropractor (D.C.) in which payment would be made to a Physician providing the same services. The treatment must be:

1. Medically necessary and indicated for the diagnosis;
2. Rehabilitative, as opposed to preventative in nature; and
3. Consistent with the diagnosis for the frequency and/or duration of the services provided.

Subject to a Calendar Year Maximum payable of $2,000.

Circumcision, Penal

Adult

Routine procedures are NOT a Covered Expense under This Plan. Operation to remove part or all of the foreskin on the penis.

Newborn

This is a covered expense under this Plan.

Operation to remove part or the entire foreskin of the penis.

Co-Payment

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

Coinsurance

Coinsurance is the percent of a Covered Expense that the Plan pays after satisfaction of any applicable Deductible.

Convalescent Care Facility

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

1. Begins within seven (7) days following an eligible Hospital confinement of at least five (5) 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 reasonable allowance and maximum number of 60 days per calendar year. (Additional days must be approved by the Medical Director prior to the 60 days expires.)

Cosmetic Expenses

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

Medically Necessary Services only if to correct:

1. Condition resulting from an illness;
2. Condition resulting from an Accidental Injury; or
3. Condition resulting from Birth Defect or Bodily Malfunction.

This Plan 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 Plan.

Services which are custodial in nature or primarily consist of bathing, dressing, toileting, feeding, and homemaking, 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 *Calendar Year Deductible*.

Deductible Carry-Over Benefit

Expenses applied to one's deductible during the last three (3) months of any calendar year (where the participant was insured for the full year) also reduces the Calendar Year Deductible for the following year by that same amount.

Dental Care

Under this medical plan, 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 erupted, 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 plan.

Diagnostic Services

Diagnostic x-ray and laboratory examinations; services of a professional radiologist or pathologist.

Dialysis Treatment - Outpatient

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,

(3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and

(iii) The specific targeting of the Plan and other non-governmental and noncommercial plans by the dialysis providers as profit centers, and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after July 1, 2010, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the

claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

Drugs

See *Patient First Prescription Drug Coverage*.

Durable Medical Equipment

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 Plan Administrator. It is recommended that you obtain prior approval for all DME services.

Eating Disorders

See *Anorexia, Bulimia, Obesity*.

Educational Services

Testing in connection with learning disorders or attention deficit disorders, etc. (i.e. testing for disorders listed in the DSM)

Educational Services, Diabetes

Up to three (3), one-hour sessions will be covered at 100% per lifetime.

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.

Elective Sterilization Reversals

This is NOT a covered expense under this Plan.

Emergency Room Services

For Accident related services see *Accident Expense.*

Non-Accident, Non-Emergency Services has a $25 up-front fee, which will be waived if admitted. Additional charges are subject to the Deductible and applicable Coinsurance.

Treatment for services rendered in a Hospital Emergency Room. See also *Urgent Care Facility*.

Employee Claim Incentive

The maximum award per occurrence is $500.

All employees are encouraged to review their medical bills for accuracy. If an error is discovered, this Plan will reimburse one-third ($^1/_3$) of the savings to the employee for the employee's diligence.

Employment Related Injury or Illness

This is NOT a covered expense under this Plan.

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 Charges

This Plan uses the 90th percentile for Reasonable 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 Plan

This is NOT a covered expense under this Plan.

Charges not covered, or charges for Benefits not covered under This Plan.

Experimental or Investigational Services or Supplies

This is NOT a covered expense under this Plan.

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 Plan.

Charges for services or supplies rendered by the Employee, Employee's Spouse, or the Children, Brothers, Sisters, Parents, or Grandparents of either the Employee or the Employee's Spouse.

Flu Vaccinations

Annual flu vaccines will be covered by the University at no cost to the Faculty and Staff members. Family members will be charged a reduced fee at their own expense. The vaccines are to be administered by Mercer Health Systems on the Macon campus and Campus Health Care on the Atlanta campus.

Foreign Assignments

When temporarily assigned 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 Plan.

Foreign Travel

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 Plan.

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 Plan.

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 Plan if the following conditions are met:

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

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

Government Owned / Operated Facility

This is NOT a covered expense under this Plan.

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 Plan.

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 Plan.

An electronic amplifying device designed to bring sound more effectively in the ear.

Hearing Exams

This is NOT a covered expense under this Plan.

Examinations to evaluate hearing quality or loss by a licensed Physician or facility.

Home Health Care

Each visit by a nurse or therapist will be considered one visit and four (4) hours of home health aide services will be considered one visit. Maximum number of visits limited to one hundred twenty (120) per calendar year.

If you live in a rural area which does not have a nearby home health care agency, private duty nursing services for up to 60 days per calendar year may be covered, but there is a maximum allowance of one (1) visit per twenty-four (24) hour period (subject to all other conditions and limitations).

Please call one of the nurse case managers at CHS (478-741-3521 or 888-741-CORE) for assistance in making home health care arrangements. If there are no In-Network Home Care Agencies, there is no penalty for going Out-of-Network.

The patient should be under the direct care and supervision of a Physician and the Physician should have a written plan of treatment which should be reviewed and renewed at least every sixty (60) days. Each visit by a nurse or therapist of the home health agency shall be considered as one home health care visit. The patient should require skilled care as opposed to assistance with activities of daily living. There should also be the capacity for improvement or the need for continued care to prevent deterioration for the condition being treated.

Skilled nursing services by a state licensed home health care agency and delivered by one of the following health professionals would be covered:

1. Registered Nurse (R.N.);
2. Licensed Vocational or Practical Nurse (LVN/LPN);
3. Physical Therapist;
4. Occupational Therapist;
5. Speech Therapist; and
6. Home Health Aide in conjunction with Skilled Nursing care when rendered under the supervision of a Registered Nurse.
7. Physiotherapist; 8. Inhalation Therapist; and
9. Social Worker Services.

In addition, the following will be covered if prescribed by a Physician and to the extent such charges would have been covered under the Plan:

1. Prescribed Drugs;
2. Medical Supplies prescribed by a physician
3. Related pharmaceutical services;
4. Laboratory services.
5. Nutritional guidance when medically necessary;
6. Oxygen and its administration; and
7. Dialysis Treatment.

Services *NOT* covered include:

1. Improvements to home such as handrails, ramps, air conditioners, telephones, whirlpool tubs, or other similar appliances and devices;
2. Food services such as "Meals on Wheels";
3. Custodial or non-medical services;
4. Social workers services;
5. Services provided by a family member or household member;
6. Housekeeping services except by home health aides as ordered in the home health care treatment plan and in conjunction with Skilled Nursing Services;
7. Maintenance therapy;
8. Babysitting services;
9. Transportation;
10. Any period during which the patient is not under the continuing care of a Physician or does not have an updated treatment plan;
11. Not medically necessary services; or
12. Purchase of dialysis equipment.

Hospice Care

Inpatient or outpatient hospice care is covered to the Plan maximum provided that a written plan of treatment is furnished as part of the claim submission. The Hospice plan 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 sixty (60) days;
3. A prognosis that the patient is terminally ill and has six 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 Plan;
3. Intermittent nursing care;
4. Physician charges;
5. Intermittent home health aide services (up to 8 hours per day);
6. Psychological counseling;
7. Physical or occupational therapy (for palliative reasons only);
8. Respite care that is continuous care in the most appropriate setting for a maximum of five days;
9. Rental of durable medical equipment when prescribed by a Physician; and
10. Nutritional Guidance when medically necessary.

In addition to General Limitations in the Plan, 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. Services of a social worker;
11. Any services or supplies not included in the plan of treatment;

12. Services performed by a family member, household member, or volunteer worker;
13. Separate charges for records and reports; and
14. Expenses for the normal necessities of living, such as food, clothing, and household supplies.

Hospital Admissions

All Hospital Admissions must be Medically Necessary.

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

Hospital Services

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).

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 Plan.

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

Immunizations

See *Routine Physical Exams* and *Well Baby Care*. Also see *Prescription Drugs* for Zoster (Shingles) and Pneumococcal vaccine coverage.

Incapacitated Child Provision The child must be:

1. Unmarried and incapable of self-sustaining employment because of intellectual disability or physical handicap that existed before the child reached the limiting age;
2. Be chiefly dependent on the employee for support; and 3. Charges are not a covered expense under a conversion policy.

To qualify for continued coverage under the Incapacitated Child provision, the child must meet specific requirements as defined in This Plan. The appropriate form may be obtained from the Benefits office.

Infertility Treatment

This is NOT a covered expense under this Plan; 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

Testing services in connection with Learning Disorders including such disorders as Attention Deficit Disorder and Dyslexia.

Lifetime Maximum Benefit

The maximum amount The Plan will pay for Covered Expenses incurred during a covered participant's lifetime or by each of their covered dependents during the dependent's lifetime.

Unless otherwise noted under a specific Covered Expense area, all benefits are subject to the Lifetime Maximum Benefit.

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

Mammogram

When covered, age thirty-five (35) years and older, one Mammogram procedure per year. For females under age thirty-five (35), 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

Procedure to remove one or both breast(s), including any reconstruction surgery as well as surgery to produce a symmetrical appearance. [2]

Maternity Expenses

This Plan, 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 Plan may not, under federal law, require that a provider attain authorization from The Plan for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours as applicable). However, This Plan 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 benefit is payable as any other benefit.

Covered conditions include (whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis, or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions, psychiatric conditions, marriage, and family counseling.

This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affecting disorders, personality or mood disorders, psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems, and eating disorders such as anorexia and bulimia. This is intended to include disorders, conditions, and illnesses listed in the Diagnostic & Statistical Manual of Mental Disorders.

Services must be provided 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.

Covered In-Patient Treatment Confinements for:

1. Acute & sub-acute mood disorders;
2. Content disorders with major depression or elation (e.g., delusional states, hallucinations, schizophrenia, or paranoid states);
3. Toxic psychoses secondary to chemicals or drugs.

The following conditions will NOT be covered when furnished on an In-Patient basis unless the condition is a major impairment of the Covered Person's ability to function outside the Hospital.

1. Conditions resulting from acute reaction to stress;
2. Conditions resulting from childhood adolescent adjustment reaction;
3. Conditions resulting from marital, social, cultural, or work situations;
4. Conditions which require only custodial and/or environment control;
5. Treatment in homes, halfway houses, schools and/or domiciliary institutions; and
6. Conditions which primarily involve custodial care, including intellectual disability, organic brain syndrome, non-psychotic brain syndromes and neuroses which are of a functional type origin;

To be considered a major impairment of the Covered Person's ability to function outside the Hospital, there must be clinical evidence of continual loss of contact with reality reflected by disorders of perception, thinking, emotion, and personal orientation. The Covered Person must also demonstrate significant signs or symptoms of being a potential danger to self or others.
See also *Chemical Dependency / Alcoholism*.

Multiple Procedures

When two or more operations or procedures are performed at the same time, and the second procedure is merely incidental, benefits are provided for Primary Procedure. A Primary Procedure is the major surgical procedure. An Incidental Surgical Procedure is one done during the primary surgery without regard to a specific condition, or a procedure done at the time as a Primary Procedure, which does not add to the time or complexity of the surgery.

When two or more operations are performed at the same time, benefits are provided for the Primary Procedures plus one-half ($^1/_2$) of the amount payable for the Secondary Procedure. A Secondary Procedure is one done at the same time as the Primary Procedure, which adds to the time or complexity of the surgery.

Network

The Networks for This Plan are:
Patient First Network (P1N) (Inside Georgia) http://www.p1n.net
First Health Network (Outside Georgia) *http://firsthealth.coventryhealthcare.com*

Network refers to those hospitals and physicians which This Plan has contracted with in order to obtain certain discounted fees. Each Covered Person under This Plan, 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 CHS 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.

Whenever there is not a Network provider within 30 miles of a Covered person's residence, there is no penalty for going Out-of-Network, and all applicable, otherwise Covered Expenses, will be paid at the In-Network Reimbursement Rate. In these situations, please advise CHS of the travel distance.

Newborn Expenses

Newborn Expenses (all Physician and facility fees), from birth until discharge, for routine care will be paid provided coverage is requested within thirty-one (31) days of the child's birth. (All enrollment cards must be submitted within thirty-one (31) days of the date of child's birth.) These expenses will be paid under the Mother.

If the baby is ill, suffers an injury, or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expenses provided coverage is in effect. These expenses will be paid under the Newborn. See also Routine *Well Baby Care*.

No Legal Obligation to Pay

This is NOT a covered expense under this Plan.

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 Plan.

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 Plan.

Treatment, counseling, supplies, medication or surgery primarily intended for weight loss.

Out-of-Pocket Limit

See *Calendar Year Out of Pocket Maximum*.

Oxygen

Oxygen and its administration when prescribed by a licensed Physician.

Pap Smears

See *Routine Physical Exams*.

Personal Hygiene

This is NOT a covered expense under this Plan.

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

Fees charged by a Physician for Medical and Surgical services in connection with a Covered Illness or Injury, and fees for the services of an Assistant Surgeon when required.

See also *Assistant Surgeon*.

Physician Assistant Services

Medically Necessary Services provided by a Physician Assistant that are performed under the supervision of a covered physician.

Physician Charges, Certain

This is NOT a covered expense under this Plan.

Charges for failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage.

Physician Charges, Electronic.

Charges for telephone consultations (including both audio and video format) are a covered expense when all these conditions are met:

- Services must be for an established patient
- Services must not be for treatment of a "new" condition.

Consultations must be interim as a convenience due to travel greater than 30 miles and NOT a primary means of care. Consultations with any staff other than the physician are not a covered expense. Calls requesting prescription refills are not a covered expense.

Podiatry

Custom Shoes are limited to one pair (up to $200) per Calendar Year.

Palliative foot care, including flat foot conditions, treatment of corns, calluses, bunions, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.

Pre-Admission Testing

Pre-Admission Testing performed within three (3) days prior to the scheduled admission for the diagnosed condition, will be reimbursed at 100%, waiving the deductible.

Pre-Existing Conditions[4]

This Plan 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 Plan, 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 Plan.

Blood testing for the purpose of obtaining a Marriage License.

Prescription Drug Benefit

See Patient First Prescription Drug Benefit Section.

Prophylactic Services

This is not a Covered Expense under This Plan.

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 Plan, prophylactic or preventative services includes (but is not limited to) surgery, facility charges, prescription drugs, and/or testing.

See also *Genetic Testing*.

Prostate Exam

Exam for males age Forty (40) years and older, one per year. For males under age Forty (40), one exam per year only if determined to be Medically Necessary.

See *Routine Physical Exams* for Coverage.

Prosthetics

Artificial limbs and eyes (standard prosthetic devices only) needed to ease or correct a condition when necessitated as the result of a physical illness or injury.

Charges for a replacement or duplication of the appliance will be covered only when required because of a pathological change (normal wear) or the natural growth process.

Radiation

Medically Necessary treatment of disease by Radium and radioactive isotope therapy.

Reconstructive Surgery

Repair of a body part due to Injury or Illness when determined to be Medically Necessary.

Repatriation

In the event a Covered Person should die from a Covered Injury or Illness, This Plan will pay the necessary expenses (at 100%, waiving the deductible), to a maximum of $15,000, for the preparation and transportation of the Covered Person's body to the Covered Person's Home Country.

Robotic Assisted Surgery Policy

For the purposes of This Plan, 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, In-Network*

The following benefits, which are available for all persons over age one covered under the Plan when an in-network provider performs services. You must participate in Mercer's group health plan to receive this benefit.

The Routine Annual Exam Benefit includes the office visit along accompanied by any of the following tests administered at a Healthcare Facility In-Network. Tests included when prescribed in conjunction with the routine annual exam are, pap smears, prostate exams, and/or immunizations when administered at a registered healthcare facility)

1. The First $300 is paid at 100%, waiving the Deductible;
2. Charges incurred for Routine Physical Exams in excess of $300 are payable at 80%, waiving the Deductible.
3. This benefit is available to all covered Participants over age one.

Routine Mammograms are paid at 100%, waiving the Deductible

Immunizations required solely for foreign travel are NOT COVERED. For Vision and Hearing services, refer to those sections. They are not considered a part of this benefit.

Routine Physical Exams, Out-Of-Network*

The following benefits that are available for all persons over age one covered under this Plan when services are performed by an out of network provider (In-Network providers are paid as per the prior description). You must participate in Mercer's group health plan to receive this benefit.

Annual exams to include:

1. Mammogram,
2. Pap smear and the lab and office visit charges associated with it, and
3. Prostate exam and the office visit charges associated with it, and
4. Immunizations when recommended by a licensed Physician and administered at a registered Healthcare facility.

All Charges are subject to the Deductible, and then payable at 60%. Immunizations required solely for foreign travel are NOT COVERED. For Vision and Hearing services, refer to those sections. They are not considered a part of this benefit.

Routine Well Baby Care (In-Network)

The following benefits, which are available for all persons under one year of age, are covered under the Plan when an in-network provider performs services. You must participate in Mercer's group health plan to receive this benefit.

The Well Baby Care Benefit includes routine office visits accompanied by standardized immunizations at a Healthcare Facility In-Network. (*Costs associated with treatment of sickness, injury, or diseases and immunizations required solely for foreign travel are excluded from this benefit.*)

1. The First $400 is paid at 100%, waiving the Deductible;
2. Charges incurred for Routine Well Baby Care in excess of $400 are payable at 80%, waiving the Deductible.

3. This benefit is available to all covered Participants under age one.

For Children over one year of age, refer to *Routine Physical Exams*. See also *Newborn Expenses*.

Routine Well Baby Care (Out-of-Network)

All Charges are subject to the Deductible, and then payable at 60%.

See also *Newborn Expenses*.

Second Surgical Opinion

Benefits are paid at 100%, waiving the Deductible if all the following is applicable.

A Second Surgical Opinion is recommended, and may be required, when any surgical procedure is to be performed on an inpatient or outpatient basis. If the Second Surgical Opinion does not confirm that the proposed surgery is Medically Necessary, a Third Surgical Opinion may also by obtained, the cost for which will be covered as provided in The Plan provided the following requirements are met:

1. The Second or Third Opinion must be obtained before the surgery is performed. No benefits will be paid for Opinions obtained after the surgery is performed.
2. A Specialist who is certified or is eligible to be certified in the field related to the proposed surgery must provide the Opinion.
3. The Specialist rendering the Second or Third Opinion does not perform the surgery.

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

Secondary Coverage

Plan members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the member incurring costs which are not covered by the Plan, which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such cost are payable in any event by the Plan.

Self-Inflicted Injuries

This is NOT a covered expense under this Plan.

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 Plan.*

Therapy – *This is NOT a covered expense under this Plan.*

Counseling – *This is NOT a covered expense under this Plan.*

Medication – See *Prescription Drug Coverage.*

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

See also *Prescription Drug Coverage*.

Sterilization

Procedures such as Vasectomies and tubal ligations, regardless of Medically Necessity.

Supplies, Diabetic (requires prescription from physician)

Needles, syringes, lancets, clini-test, glucose strips and chem-strips for diagnosed diabetes.

See *Prescription Drug Coverage*.

Supplies, Medical and Surgical

Casts, splints, trusses, braces, crutches, surgical dressings and supplies, including ostomy supplies and similar Medically Necessary medical and surgical supplies as prescribed by a licensed Physician.

See also *Supplies, Diabetic*.

Temporomandibular Joint Syndrome (TMJ)

Treatment of TMJ up to a Maximum indicated including only removable appliances for TMJ repositioning and related diagnostic services, excluding fixed or removable appliances which involve movement or reposition of the teeth, operative restoration of teeth (fillings) or prosthetics (crown, bridges and dentures). $1,000 Lifetime benefit maximum.

Therapy

Precertification required for occupational therapy, pulmonary therapy and speech therapy.

Biofeedback, Recreational or Educational
See specific treatment, therapy or program.
Occupational 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 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.
Massage therapy is covered only when prescribed by a licensed physician to correct, alleviate or limit physical disability, bodily malfunction, or pain from injury or disease. Please contact Core Administrative Services as limitations do apply.
Pulmonary Rehabilitation *This is a covered expense under the Program.*
Medically prescribed Pulmonary Rehabilitation rendered by a duly qualified Therapist to structure a program of activity, progressive breathing and conditioning exercise, and patient education designed to return patients with pulmonary disease to maximum function. See also *Rehabilitation Care*
Speech
Congenital conditions or diseases causing delayed speech development in children are NOT a Covered Expense under This Plan. 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, Non-Human to Human

Any non-experimental or non-investigative Animal Organ or Tissue, Artificial or mechanical transplants and surgical or medical care related to such procedures.

Transplant, Organ

The following expenses will be eligible, but are limited to the expenses shown below:

1. Organ and tissue procurement consisting of removing, preserving and transporting the donated part, including the surgical replacement procedure when:
    a. Both the recipient and the donor are Covered by This Plan, services will be covered for each patient;
    b. Only the recipient is Covered by This Plan, benefits are provided for services for both the recipient and donor, provided benefits to the donor are not furnished under some other form of surgical-medical coverage;
    c. The recipient is NOT Covered by This Plan and the donor is Covered by This Plan, expenses will NOT be covered for either the recipient or the donor.
2. Transportation, Lodging and meals costs – LIMITED TO A $10,000 MAXIMUM PER TRANSPLANT. Covered expenses include the following:
    a. Reimbursement for transportation of the recipient and a companion ($0.32 per mile) to and from the site of the Transplant. If the recipient is a minor, transportation of two (2) persons who travel with the minor will be allowed;

b. Lodging and meal costs incurred in the interim by such companion(s) during the hospital confinement period up to $200 per day per person.
c. If the recipient is required to remain in the vicinity of the hospital for a period of time following the transplant for follow up care and the recipient cannot be transported from home due to distance, expenses for lodging and meals will be allowed for the recipient and a companion up to $200 per day per person.
d. All above outlined expenses are subject to the $10,000 maximum per transplant.

Medically Necessary organ or tissue transplant procedures which are not experimental or not investigational and all related Covered Expenses when incurred by a Covered Person who is the recipient of such transplant.

Transsexual Surgery

This is NOT a covered expense under this Plan.

Charges leading to or in connection with Transsexual Surgery.

Urgent Care Facility

A facility dedicated to the delivery of medical care outside of a hospital emergency department, usually unscheduled, walk-in basis. Urgent Care Facility primarily treats patients who have an injury or illness that requires immediate care, which is not a Physician's office, clinic, hospital or ambulatory surgical facility. Use of these types of facilities is *NOT* considered the same as using a Hospital Emergency Room.

For Accident Related Services see *Accident Expense*.

Non-Accident Services charges are subject to the Deductible and applicable Coinsurance. There are no Co-Pays for this type of facility.

Vision Expenses

This is NOT a covered expense under This Plan.

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).

See also *Cataract Surgery, Eye Wear Afterwards*.

War or Acts of War

This is NOT a covered expense under this Plan.

Declared or undeclared, including an Injury sustained or Illness contracted while on duty with any Military Service for any country.

General Limitations and Exclusions – Medical

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

1. 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;

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

3. 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;

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

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

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

7. Charges for benefits other than specifically provided or in excess of the benefits specified in This Plan; (a) gestational carrier and her maternity care, (b) complications that occur as a result of being a gestational carrier;

8. 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;

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

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

11. 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.

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

EXCLUSIONS:

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

Abortion. Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered.

Acupuncture. Services, supplies, care or treatment in connection with acupuncture;

Alcoholism. 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 Plan. 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;

Artificial Insemination. Services, supplies, care or treatment in connection with artificial insemination, the treatment of sexual dysfunctions not related to organic disease or treatment relating to the inability to conceive;

Circumcision, Penal – Adult. Services, supplies, care or treatment in connection with an adult penal circumcision;

Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under This Plan. Complications from a non-covered abortion are covered;

Cosmetic Expenses. Services, supplies, care or treatment for procedures that are not medically necessary are deemed to be cosmetic in nature;

Custodial Care. Services or supplies provided mainly as a rest cure, maintenance or custodial care;

Dental Care. Services, supplies, care or treatment of teeth, except as outlined elsewhere in this document;

Education or Vocational Testing. Services for educational or vocational testing or training;

Employment Related Injury or Illness. Services, supplies, care or treatment of an injury or illness that is occupational - that is, arises 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;

Exercise Programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by This Plan;

Eye Care. Radial keratotomy or other eye surgery to correct refractive disorders. Also routine eye examinations, including refractions, 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;

Family Provided Services. Services or supplies rendered by the Employee, Employee's spouse, or the children, brothers, sisters, parents or grandparents of either the Employee or the Employee's spouse;

Foreign Travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services;

Gastric Bypass Surgery/Bariatric Surgery. Services, supplies, care or treatment

Government Owned/Operated Facility. Services, supplies, care or treatment provided by a facility owned or operated by the U.S. Federal, State of 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 Loss. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician;

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;

Illegal Acts. Charges for 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;

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 Plan. This exclusion does not apply if Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition; **Infertility Treatment.** Services, supplies care or treatment for infertility, artificial insemination, or in vitro fertilization;

No Charge. Care and treatment for which there would not have been a charge if no coverage had been in force;

No Legal Obligation to Pay. Charges incurred for which the Plan has no legal obligation to pay;

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;

Non-emergency Hospital Admissions. Care and treatment billed by a Hospital for nonmedical emergency admissions on a Friday or Saturday. This does not apply if surgery is performed within twenty-four (24) hours of admission;

Not Medically Necessary. Services, supplies, care or treatment for an Injury or Illness which is not medically necessary;

Not Specified as Covered. Non-traditional medical services, treatments and supplies which are not specified as covered under This Plan;

Obesity or Weight Control. Services, supplies, care or treatment of obesity, weight loss or dietary control including diet supplements, enrollment in a health, athletic or similar club. This also includes surgical correction. Medically necessary charges for Morbid Obesity will be covered.

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;

Physician Charges, Certain. Charges for telephone consultations, failure to keep scheduled appointments, completion of claim forms or providing medical information necessary to determine coverage;

Pre-Marital Exams. Blood testing for the purpose of obtaining a marriage license;

Self-Inflicted Injuries. Charges for services, supplies, care or treatment furnished in connection with intentionally self-inflicted injuries or suicide, whether committed while sane or insane;

Services Before or After Coverage. Services, supplies, care or treatment for which a charge was incurred before a person was covered under This Plan or after coverage ceased under This Plan;

Sex Changes. Services, supplies, care or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, and surgery, medical or psychiatric treatment;

Sleep Disorders. Services, supplies, care or treatment for sleep disorders (including sleep labs) unless deemed Medically Necessary;

Spinal Decompression. Services, supplies, care or treatment related to spinal decompression as performed by facilities such as The Back Pain Institute;

War or Acts of War. Charges incurred in connection with the care or treatment of any sickness contracted or Injury sustained which is occupational or which results from war or any act of war, declared or undeclared;

Patient First Prescription Drug Expense Benefit

Benefits are payable when a Covered Person incurs eligible drug expenses which are in excess of the co-payment 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 Patient First system. The Covered Person must show the Patient First ID card in order to obtain the appropriate Co-Pay. In the event the Covered Person must pay full retail price, the insured should file their claims through Patient First. Forms may be obtained through the benefits office or CHS.

PARTICIPATING PHARMACIES
Use the Patient First card at any participating pharmacy.

Each Covered Person will be responsible for the required co-payment at the time of purchase. The remainder of the transaction will be handled between Patient First and the pharmacy.

The Covered Person is expected to show the Patient First 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 CHS) 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 Patient First system.

NO Coordination of Benefits will apply for Prescription Drug Coverage.

Prescription Drug Coverage

This Plan 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 Plan:

C = Covered / N = Not Covered

A.D.D. / Narcolepsy
C Amphetamines / Detroamphetamine (e.g. Adderall)
C Dextroamphetamine (e.g. Dexedrine) / through age 18

C Methylphenidate (e.g. Ritalin) / through age 18
C Pemoline (e.g. Cylert) / through age 18

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

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

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

Birth Control (Contraceptives)
C Oral dosage forms (e.g. Ortho Novum, Demulen) C
Non-oral dosage forms (e.g. IUD, Diaphragm)
C Injectable dosage forms (e.g. Depo Provera)
N Levonorgestrel (Norplant) 5 year implant

Controlled Substances
C Class 2
C Class 3
C Class 4
C Class 5

Cosmetic Medication
C Accutane (for acne)
N Anti-wrinkle agents (e.g. Renova)
C Retin-A through age 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)

C Insulin and needles/syringe under one copay
C Insulin, needles/syringes, and test strips under one copay

See also *Educational Services/Diabetes*.

Experimental or Investigational Drugs
This is NOT a covered expense under this Plan.
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 recommended.
C Therapeutic classifications (e.g. Hivid, Epivir, Videx, Zervit)

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

Immunizations
Covered at 100%, no member cost share, no age restriction
C Zoster vaccine (Shingles)
C Pneumococcal vaccine (Pnenmonia) C
Influenza vaccine (Flu)

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)
C Growth Hormones (e.g. Humatropin, Genotropin) to age 18. Pre-notification through CHS recommended.
N Immunization Agents (e.g. Hepatitis, Chicken Pox) (See *Routine Physical Exams*)
N Levonorgestrel (Norplant) (See *Birth Control*)
N Minoxidil (Rogaine-for the loss of hair)

Non-Legend Drugs
N Over-the-counter medications

Nutritional Supplements
N Non-legend vitamins (over the counter)
C Legend vitamins (Rx required)
C 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 Plan.
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 Plan.
Therapeutic devices or appliances, including needles, syringes (except as specified), support garments and other non-medicinal substances, regardless of intended use.

Comprehensive Dental Expense Benefit

The Comprehensive Dental 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 Dentist or Physician; and
3. Provided for care and treatment of a Covered Illness or Injury;

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

Dental Schedule of Benefits

Available to: Regular Full-Time Employees

The Mercer Dental Plan is a self-insured plan, which does not restrict participants to utilizing any specific dentists or facilities; you may choose your own dental providers. This Plan will pay eligible charges at the percentages shown, based on Reasonable fees once the deductible has been met. Refer to Dental Plan Payment Provisions for detailed description of services or benefits. **There is a one-year wait provision for Major Restorative Services (bridges, crowns, partials, etc.) and Orthodontic Services.**

Basic Services

Eligible charges are subject to Calendar Year individual deductible; balance then payable at 80% of the next $750, and 50% of the next $1,200 in charges. Please refer to Dental Plan Payment Provisions for more details.

Calendar Year Deductible

Individual Deductible $75 for ALL services
Family Deductible $225 for ALL services

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

The Family Deductible may be satisfied with a combination of any Covered Participants' eligible expenses within a given Family unit. No one Covered Participant will have more than the Individual Deductible to satisfy. Once the Family Deductible has been satisfied, the applicable Coinsurance will be applied for all Family members that are Covered Participants.

Calendar Year Benefit Maximum

The Calendar Year Maximum Benefit under this Plan is $1,200 per Covered Person. This is the total amount payable for covered dental services (not including Orthodontic Benefit) incurred by a Covered Person during the Calendar Year.

Claims Are Paid Based On

Medical Necessity of the Services Being Provided

Coinsurance

The Coinsurance for This Plan per Calendar Year is as follows:

80% of the next $750
50% of the next $1,200

Deductible

See Calendar Year Deductible.

Dental Provider

Any Dentist licensed to practice

Effective Date of Coverage

1st Day of Month Following Date of Hire or Eligibility

Employee Eligibility

The term "Regular Full-time Employee" includes all employees (Faculty, Staff, Visiting Faculty, and Full-time Residents) hired to work a minimum of 30 hours per week on an on-going basis.

The term “Regular Part-time Employee” includes all employees who work at least 20 hours per week, but less than 30 hours per week on a regular basis, for a total of at least 1,000 hours or more in a year.

The term "Temporary or Seasonal Employee" includes all employees hired to work temporarily, only part of the time during the year following their first day of employment. Unlike "Regular Full-time" and "Regular Part-time" these employees are hired only for a short time (usually less than six months) as additional staffing becomes necessary for special programs or events. "Temporary or Seasonal Employees" whether full-time or part-time, are not considered eligible for benefits under this plan.

The term “Classified Employee” includes all employees whose positions are included in the University’s Classification system. In general, these are all Full-Time and Part-Time Regular employees except Faculty, Executives, and employees in certain Administrative and Professional positions.

The Employee portion of the Premium Payments of the Benefits described in this Summary may be paid through Salary Deduction with Pre-Tax or After Tax Dollars. All Premiums contained in this Summary are subject to change and should be verified through the University’s Benefits Office for current accuracy.

Employee Claim Incentive

The maximum award per occurrence is $500.

All employees are encouraged to review their dental bills for accuracy. If an error is discovered, this Plan will reimburse one-third (1/3) of the savings to the employee for the employee's diligence.

Five Year Rule

Charges for replacing an appliance or prosthetic device, such as a denture, crown or bridge will not be covered unless it is at least five (5) years old or cannot be made usable.

Implants

Implants (material implanted into or on bone or soft tissue) or the removal of implants.
Please refer to Dental Plan Payment Provisions for more details.

Major Services

No Major Services will be covered under This Plan for the first twelve (12) months of Coverage.

Eligible charges are subject to Calendar Year individual deductible, balance then payable at 80% of the next $750, and 50% of the next $1,200 in charges. Please refer to Dental Plan Payment Provisions for more details.

Orthodontic Benefits

Eligible charges are subject to Calendar Year individual deductible, balance then payable at 50%. Orthodontic payments have a Lifetime Maximum benefit of $1,000 per covered person. Orthodontic payments will not reduce the maximum benefit per calendar year for other covered dental charges. Please refer to Dental Plan Payment Provisions for more details.

Sealants

Application of Sealants (Limited to Children under age 14)

Teeth Lost Before Covered Under This Plan

There are no benefits for a prosthetic devise which replaces teeth lost before becoming covered under this Plan, unless the devise also replaces one or more natural teeth lost or extracted after the Covered Person became covered under this Plan.

Dental Plan Payment Provisions

The following is a complete list of Covered Dental Procedures under this Dental Expense Benefit. Cosmetic procedures are not covered under this plan. Calendar Year Deductible applies to **ALL** dental services.

Covered charges for Dental Expenses will be considered incurred as follows:

1. For a prosthetic device, on the date the master impression is made;
2. For a crown, a bridge or cast restoration, on the date the tooth or teeth are prepared;
3. For root canal treatment, on the date the pulp chamber is opened;
4. For Orthodontic treatment, on the date the active appliance is first placed; 5. For all other charges, on the date service is rendered or a supply is furnished.

Preventative Services

1. Prophylaxis and fluoride treatments, including:

    a. Examination, scaling and polishing;
    b. Topical application of fluoride; and
    c. Application of Sealant (Limited to Children under age 14).

2. Space Maintainers (limited to the initial appliance only and for children under age 16 only) including:

    a. All adjustments in the first six (6) months after installation;
    b. Fixed, unilateral, bond or stainless steel crown type;
    c. Fixed, unilateral, cast type; or
    d. Removable, bilateral type.

3. Fixed and removable appliances to inhibit thumb sucking and other harmful habits (limited to Covered Persons under age sixteen (16), and limited to the appliance only) including all adjustments in the first six (6) months after installation.

4. Diagnostic Services including:
    a. Examination and Diagnosis;
    b. X-rays:F
        1. Full mouth series of at least fourteen (14) films including bitewings, if needed;
        2. Bitewing films;
        3. Other intraoral periapical or occlusal films, single films;
        4. Extraoral superior or inferior maxillary film;
        5. Panoramic film, maxilla and mandible;
        6. Initial or periodic oral examination;
        7. Emergency palliative treatment and other non-routine unscheduled visits.

5. Emergency Treatment including Outpatient treatment of Injuries resulting from an accident.

Basic Services

1. Office visits and examinations:
   (For Diagnostic consultation with a Dentist other than the one providing treatment, payment is only made if no other service is rendered during the visit).

2. Diagnostic services including:
   a. Examination and diagnosis;
   b. Diagnostic casts; and
   c. Biopsy and examination of oral tissue.

3. Restorative services (multiple restorations on one surface will be considered one restoration) including:
   a. Amalgam restorations;
   b. Synthetic restorations:
      1. Silicate cement;
      2. Acrylic or plastic;
      3. Composite resin;
   c. Crowns:
      1. Temporary Crowns;
      2. Stainless crowns;
   d. Pins:
      1. Pin retention, exclusive of restorative material;
   e. Re-cementation of Crowns
      1. Inlay or onlay; 2. Crown; 3. Bridge.
   f. Implants:
      These include prosthetic appliances placed into or on bone of the maxillar or Mandible (upper or lower jaw) to retain or support dental prostheses, including endosseous, transosseus, subperiosteal, and endodontic implants; implants connecting bars; implant repairs; and implant removal.

4. Endodontic services including routine x-rays and cultures, but excluding final restoration: a. Pulp capping direct;
   b. Remineralization (calcium hydroxide), as a separate procedure;
   c. Vital pulpotomy;
   d. Apexification
   e. Root canal therapy of non-vital (nerve dead) teeth:
      1. Traditional therapy;
      2. Medicated paste therapy, N2 Sargenti;

   f. Apicoectomy, as a separate procedure or in conjunction with other Endodontic procedures.

5. Periodontics services including Treatment plan, Local anesthetics, and Post-surgical care for the following:
    a. Gingivectomy or gingivoplasty, per quadrant;
    b. Gingivectomy per tooth (fewer than six (6) teeth);
    c. Subgingival curettage and root planning, per quadrant;
    d. Pedicle or free soft tissue grafts, including donor sites;
    e. Osseous surgery, including flap entry, closure per quadrant;
    f. Osseous surgery, including flap entry, closure and donor sites;
    g. Muco-gingival surgery;
    h. Occlusal adjustment not involving restorations and done in conjunction with periodontics surgery, per quadrant.

6. Oral surgery including routine X-rays, the treatment plan, local anesthetics and postsurgical care for:
    a. Extractions:
        1. Uncomplicated extraction, one or more teeth;
        2. Surgical removal of erupted teeth, involving tissue flap and bone removal; 3. Surgical removal of impacted teeth;

    b. Other surgical procedures:
        1. Alveolectomy, per quadrant;
        2. Stomatoplasty with ridge extension, per arch;
        3. Excision of pericoronal gingiva, per tooth;
        4. Removal of palatal torus;
        5. Removal of mandibular tori, per quadrant;
        6. Excision of hyperplastic tissue, per arch;
        7. Removal of cyst or tumor;
        8. Incision and drainage of abscess;
        9. Closure of oral fistula of maxillary sinus;
        10. Reimplantation of tooth;
        11. Frenectomy;
        12. Suture of soft tissue Injury;
        13. Sialolithotomy for removal of salivary calculus;
        14. Closure of salivary fistula;
        15. Dilation of salivary duct;
        16. Sequestrectomy for osteomyelitis or bone abscess, superficial; 17. Maxillary sinusotomy for removal of tooth fragment or foreign body.

7. Denture Services including:
    a. Denture repairs, acrylic:
        1. Repairing dentures, no teeth damaged;
        2. Repairing dentures and replacing one or more broken teeth;

3. Replacing one or more broken teeth, no other damage;

b. Denture repairs, metal;
c. Denture reline:
   1. Office reline, cold cure; 2. Laboratory reline;

d. Denture duplication, jump case;
e. Denture adjustments;
f. Tissue conditioning;
g. Adding teeth to partial dentures to replace extracted natural teeth;
h. Repairs to crowns and bridges.

Excluding specialized techniques and characterization.

8. Other services:
   a. General anesthesia in conjunction with surgical procedures only;
   b. Injectable antibiotics needed solely for treatment of a dental condition.

Major Services

No Major Services will be covered under this plan for the first twelve (12) months of coverage.

1. Prosthodontic services:

   a. Dentures and all adjustments performed by the Dentist furnishing the dentures:
      1. Full dentures, upper or lower;
      2. Partial dentures including base, all clasps, rests, teeth and:
         a. Upper, with two (2) chrome clasps with rests, acrylic base;
         b. Upper, with chrome palatal bar and clasps, acrylic base;
         c. Lower, with two (2) chrome clasps with rests, acrylic base;
         d. Lower, with chrome lingual bar and clasps, acrylic base;
         e. Stayplate base, upper or lower (anterior teeth only);

   b. Fixed bridges (each abutment and each pontic makes up a unit in a bridge): 1. Bridge abutments (see inlays and crowns under); 2. Bridge pontics:
      a. Cast metal, sanitary;
      b. Plastic or porcelain with metal;
      c. Slotted facing;
      d. Slotted pontic;
      3. Simple stress breakers, per unit;
      4. Removable bridges, unilateral partial, one-piece chrome casting, clasp attachment, including pontics.

Excluding charges for specialized techniques and characterizations.

2. Restorative services; cast restorations and crowns are covered only when needed because of decay or injury, and only when the tooth cannot be restored with a routine filling material:
    1. Inlays;
    2. Onlays, in addition to inlay allowance;
    3. Crowns and posts;
        a. Acrylic with metal;
        b. Porcelain;
        c. Porcelain with metal;
        d. Full cast metal (other than stainless steel);
        e. 3/4 cast metal (other than stainless steel);
        f. Cast post and core, in addition to crown (not a thimble coping);
        g. Steel post and composite or amalgam core, in addition to crown;
        h. Cast dowel pin (one-piece with crown).

Orthodontic Services

No Orthodontic Benefits will be covered under This Plan for the first twelve (12) months of Coverage. Orthodontic Benefits include the following:

1. Any of the Covered Dental Expenses in This Plan in connection with Orthodontic treatment, including the movement of one or more teeth by the use of active appliances. It also includes:
    1. Diagnostic Services;
    2. The Treatment Plan;
    3. The fitting, making, and placement of an active appliance; and
    4. All related office visits, including post-treatment stabilization.

2. Surgical exposure of impacted or erupted teeth in connection with orthodontic treatment including:
    1. Routine X-rays; 2. Local anesthetics; and
    3. Post-surgical care. *See also Orthodontic Benefit - Lifetime Maximum*

Alternative Treatment

In all cases in which there are optional treatments available which produce a professionally satisfactory result, only the least costly alternative will be considered eligible under This Plan.

Anesthesia Services

Anesthetics and their professional administration when ordered by the Attending Physician or Dentist in connection with a Covered Procedure.

Deductible Carry-Over Benefit

Expenses applied to one's deductible during the last three (3) months of any calendar year (where the participant was insured for the full year) also reduces the Calendar Year Deductible for the following year by that same amount.

Foreign Assignments

When temporarily assigned 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 Plan.

Incapacitated Child Provision

The child must be:

1. Unmarried and incapable of self-sustaining employment because of intellectual disability or physical disability; and
2. Be chiefly dependent on the employee for support; and 3. Charges are not a covered expense under a conversion policy.

To qualify for continued coverage under the Incapacitated Child provision, the child must meet specific requirements as defined in This Plan.

General Limitations and Exclusions - Dental

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

1. 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;
2. Charges which would not customarily have been made if no coverage had existed, (except where prohibited by law);
3. Charges for services and supplies which are furnished without the recommendation of a Dentist or Physician for the care and treatment of an Illness or Injury, including court ordered or directed care or evaluation;
4. Charges for any services rendered outside the scope of the license of the institution or practitioner providing the service;
5. Charges which are in excess of Reasonable Charges.
6. Charges which are not Medically Necessary, or reasonably necessary to the care and treatment of an Illness or Injury;
7. Charges for benefits other than specifically provided or in excess of the benefits specified in This Plan;
8. 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;
9. Charges for travel, whether or not recommended by a Dentist or Physician.

10. 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;
11. Based on date of service, charges outside of the 12 month filing limit of the Plan.
12. Expenses for or in connection with an injury or illness arising out of the commission of a felony or an illegal occupation will not be considered eligible. This exclusion does not apply to injuries and/or illnesses sustained due to a medical condition (physical or mental) or domestic violence.
13. Charges incurred for fluoride other than for services performed in the Dentist's office as described under Preventive Services.

Assault or Illegal Occupation This is NOT a Covered Expense under This Plan.

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.

Cosmetic Expenses

This Plan 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 and are Medically Necessary.

Dentist Charges, Certain this is NOT a Covered Expense under This Plan.

Charges for telephone consultations, failure to keep scheduled appointments, completion of claim forms or providing dental information necessary to determine coverage.

Employment Related Injury or Illness this is NOT a Covered Expense under This Plan.

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 Workers' Compensation Law, Occupational Disease Law or similar legislation.

Experimental or Investigational Services or Supplies

This is NOT a Covered Expense under This Plan.

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 Federal Health Care Finance Administration 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 Plan

Charges for services or supplies rendered by the Employee, Employee's Spouse, or the Children, Brothers, Sisters, Parents, or Grandparents of either the Employee or the Employee's Spouse.

Five-Year Rule

Charges for replacing an appliance or prosthetic device, such as a denture, crown, or bridge, will not be covered, unless it is at least five (5) years old and cannot be made usable.

Foreign Travel

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 Plan.

Government Owned / Operated Facility

This is not a Covered Expense under This Plan.

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.

Not Medically Necessary This is not a Covered Expense under This Plan.

Treatment of an Injury or Illness that is not medically necessary. This includes charges for care, supplies or equipment.

Teeth Lost Before Covered Under This Plan

There are no benefits for a prosthetic device which replaces teeth lost before becoming covered under This Plan, unless the device also replaces one or more natural teeth lost or extracted after the Covered Person became covered under This Plan.

War or acts of War

This is not a covered Expense under This Plan.

Declared or undeclared, including an Injury sustained or Illness contracted while on duty with any Military Service for any country.

Pre-notification Requirements of Plan

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 an additional front end deductible of $200 on the eligible facility charges.

This Plan 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 & outpatient hospital services and certain other procedures. This includes all admissions to medical / surgical facilities, Hospital, Hospice, Home Health Care and convalescent facilities.

The Employee, patient, family member, Employer, 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 Plan provides a minimum hospital stay in connection with childbirth for the mother or newborn child of 48 hours following a vaginal delivery and 96 hours following a cesarean section. The attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

  Although This Plan recommends Pre-Notifying CHS during the first trimester of a Maternity Diagnosis and again within 48 hours of delivery of the baby, no penalties will be applied if this is not done. However, any hospital stays longer than 48 hours (or 96 hours as applicable), must be Pre-Certified, and will be subject to their Pre-Certification penalties as defined in Pre-Notification Requirements[3].

- **Emergency or Urgent Inpatient Admissions** - must be pre-certified within 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.

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:

1. Employee's name and social security number;
2. Patient's name, date of birth, sex, and contact telephone number;
3. Facility or Hospital's name, address, and telephone number;
4. Admitting Physician's name, address, and telephone number;
5. Date of admission;
6. Diagnosis and/or surgical procedure (if known); and
7. 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, or a Hospital confinement can be shortened by using home health care.

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*
- *Durable Medical Equipment (DME) over $500*
- *Echocardiogram*
- *Electroencephalogram (EEG)*
- *Esophagogastroduodenoscopy (EGD) [Upper GI]*
- *Electromyogram (EMG)*
- *Genetic Testing*
- *Heart Catheterization – If elective or if admitted*
- *HIDA Scan (Hepatobiliary Iminodiacetic Acid)*
- *Home Health Care*
- *Inpatient stay*
- *MRI (Magnetic Resonance Imaging)*
- *Nerve Conduction Studies*
- *Nuclear Scan*
- *Observation Stay (Twenty-Three (23) Hour Hospital "Observation")*
- *Organ Transplant*
- *Outpatient surgery (unless listed below)*
- *PET Scan (Positron Emission Tomography)*
- *Renal Dialysis*
- *Sleep Studies*
- *Therapies: occupational therapy, pulmonary therapy, pulmonary rehabilitation and speech therapy*

The following items do not require pre-certification:

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

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 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 employee, 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 employee wishes to appeal the decision to deny benefits for a continued confinement, he or she can submit an appeal in writing to CHS.

Core Health 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 Plan.

Eligibility and Effective Date of Coverage

Employee Eligibility

The following employees will be eligible to be covered under This Plan:

All Regular Full-Time Employees (which includes both Faculty and Staff) hired to work a minimum of 30 hours or more per week are eligible to participate in the Mercer Health Plan. The date of Eligibility is the first day the Employee is determined to be in such a Category.

If an employee qualifies as both an employee and a dependent, such person may only be covered as one of the above and not both an employee and a dependent.

Effective Date of Employee Coverage

Coverage will become effective for an employee as of the 1st day of the Month following Date of Eligibility, provided the employee is in Active Service on that date; otherwise, the effective date will be deferred until the date the employee returns to Active Service.

All eligible Employees must complete the required Enrollment Forms within 31 days of the Date of Eligibility - that is, within 31 days of the Employee's Date of Hire or within 31 days from when the Employee or Dependent first becomes eligible to participate in the Mercer Health Plan. These forms will determine the Employee's insurance coverage for the year.

Dependent Eligibility

The following persons shall be eligible to be covered as Dependents under This Plan:

1. The lawful spouse of the Employee, whether male or female. The term spouse shall mean the person recognized as the covered Employee's Legal spouse under the laws of the United States of America. The Plan Administrator my require documentation proving a legal marital relationship;

2. An Employee's child from the date of birth to age twenty-six (26) regardless of the child's financial dependency, residency, student, employment and/or marital status.

a. The Plan is NOT required to extend coverage to any child or spouse of a covered dependent child.

An intellectually disabled or physically handicapped child may continue coverage beyond the limiting age. For further details, please refer to Incapacitated Child and to the EXTENDED COVERAGE FOR DEPENDENT CHILDREN sections.

The term "child" includes the following subject to the age limits and requirements specified above:

1. The Employee's natural child;

2. A legally adopted child from the date the Employee assumes legal responsibility;

3. A stepchild as long as the natural parent remains married to the Employee and resides in the Employee's household; or
4. A legal foster child, provided that one or both of the child's natural parents does not reside with the Employee as well. In addition, the foster child is not considered a Dependent if the welfare agency provides all or part of the child's support.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights. At any time, the Plan may require proof that a Spouse or child qualifies or continues to qualify as a Dependent as defined by the Plan. All other persons are excluded.

If both parents of any Dependent Child are Covered Employees, then for the purposes of This Plan, the Dependent Child can be Dependent of one parent only.

An Employee will be eligible to enroll for Dependent Coverage on whichever of the following dates is first to occur:

1. The date the Employee is eligible for Coverage, if on that date the Employee has such Dependents;
2. The date the Employee first gains a Dependent (see EFFECTIVE DATE OF COVERAGE FOR NEWBORN CHILDREN section for details on newborns).

Effective Date of Dependent Coverage

Coverage will become effective for a Dependent, other than a Newborn Child, as indicated below, provided both the Employee and Dependent are in Active Service on that date and the Dependent is not confined in a Hospital, other institution or home on that date; otherwise, the Effective Date will be deferred until the day following a return to Active Service. A Dependent's Effective Date will be determined as follows:

1. The date on which the Employee becomes Covered if there are any Dependents on that date;
2. If the Employee is without a Dependent on the date the Employee becomes Covered, Dependent Coverage will become effective on the 1st of the month after they become eligible, provided enrollment for Coverage is made within thirty-one (31) days after the Dependent is acquired and any required contribution is paid within thirty-one (31) days after the Dependent is acquired.
3. If the Employee has Dependent Coverage, Coverage for any newly acquired Dependents (see EFFECTIVE DATE OF COVERAGE FOR NEWBORN CHILDREN section for details on Newborns) will be effective on the 1st of the month after they become eligible, provided that enrollment is made within thirty-one (31) days of the date that the Dependent is acquired and required contribution is paid within thirty-one (31) days

after the Dependent is acquired. This will be allowed under the Special Enrollment Period.

4. Each Dependent will be covered on the above Effective Date provided enrollment and any required contributions have been made within thirty-one (31) days after the date of eligibility. If a Dependent is not enrolled within thirty-one (31) days, the Dependent may not be enrolled until the following Annual Open Enrollment period unless there is another Change in Family Status prior to the Annual Open Enrollment period.

Effective Date of Coverage for Newborn Children

A Newborn Child will automatically become covered from birth (as long as an enrollment card is completed) if Dependent Coverage is in force at the time of birth. The Employee may be required to make an additional contribution if needed for the Newborn within thirty-one (31) days after the date of birth depending on previous benefit selections. Coverage will be provided to the same extent as for other Covered Dependent children. If at the time of birth the Covered Employee is acquiring the first Dependent, the Employee must enroll for Dependent Coverage within thirty-one (31) days after the date of birth.

The Employee must make an additional contribution for the Newborn from the date of birth if required by This Plan. If this is done, Dependent Coverage will become effective as of the date of birth under the Special Enrollment Period provision.

If a Newborn Child is not enrolled within thirty-one (31) days after the date of birth, the Newborn may not be enrolled until the following Annual Open Enrollment period unless there is another Change in Family Status prior to the Annual Open Enrollment period.

Change in Classification of a Covered Employee

Any change in the amount of an employee's coverage resulting from a change in the employee's classification shall become effective on the first of the month coincident with or next following the date the change occurs, provided the employee is in Active Service on that date; otherwise the effective date of the change shall be the first day on which the employee is in Active Service.

Change in classification by reason of attainment of a specified age shall be effective on the first of the following month during which the employee attains the limiting age.

Change in Classification of a Covered Dependent

Any change in the amount of a dependent’s coverage resulting from a change in the employee’s classification shall become effective on the first of the month coincident with or next following the date the change occurs, except that if on that date the dependent is not in Active Service, the change shall not become effective until such dependent returns to Active Service.

Any change in the amount of a dependent's coverage as a result of a change in the dependent status, shall automatically become effective on the date such change in dependent status becomes effective.

Qualified Medical Child Support Order (QMCSO)

QMCSO's obligate a noncustodial parent by a child support order to provide medical support for his or her children. QMCSO's require group health plans to provide benefits to a child of a participant.[5]

Please contact CHS or Benefits Administration for more information.

Effect of Prior Coverage

This Plan will not provide benefits to employees or dependents that are Totally Disabled on the date of discontinuance of the preceding plan and entitled to any extension of benefits provision.

Special consideration will be given to covered medical expenses incurred by an employee or dependent covered under the Employer's or Participating Employer's preceding group plan up to the effective date of This Plan. Those covered expenses applied to the prior plan's Calendar Year deductible amount and coinsurance limit (if any) will be applied to the respective provisions in This Plan for the same Calendar Year deductible amount and coinsurance limit upon submission of proof of consideration by the prior plan.

Changing Coverage during the Plan Year - FAMILY STATUS CHANGES

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

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

The request to add or delete coverage must be made within 31 days of the Change in Status. Failure to delete coverage for Dependents no longer eligible for coverage within the 31 day

period will not result in premiums being reimbursed for that period of time when the premiums were paid and the Dependents were not eligible, nor will claims be paid for expenses incurred during such period. See also section entitled Continuation of Coverage (COBRA).

In the event of any of the above occurrences, the Employee should notify Benefits Administration and ask for the appropriate forms necessitated by the Change in Status.

Effective Date of Coverage Change due to a Change in Family Status:

For a Marriage, Birth, or Adoption of a Child or acquisition of responsibility for a Step Child, the Effective Date of the Change will be the date of the change itself. For all other additions of coverage, the Change will be effective as of the 1st day of the Month following enrollment. For all other deletions of cover age, the change will be effective as of the last day of the month of the change itself.

Termination Date of Coverage

Termination of Employee Coverage

A Covered Employee's Coverage will terminate immediately upon termination of This Plan or on the date indicated in the GENERAL INFORMATION section, after the occurrence of the first of the following events:

1. If the Covered Employee fails to remit required contributions for Coverage when due, Coverage will terminate at the end of the period for which a contribution is made;
2. Termination of the Active Service, except as specified below and in the COVERAGE AFTER TERMINATION section;
3. When the Covered Employee enters the military, naval or air force of any country of international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
4. When the Covered Employee ceases to maintain full-time residency in the United States of America; or
5. When the Covered Employee ceases to be in a class eligible for coverage.

Termination of Dependent Coverage

A Covered Dependent's Coverage will terminate immediately upon termination of This Plan or on the date indicated in the GENERAL INFORMATION section, after the occurrence of the first of the following events:

1. When the coverage of the Covered Employee is terminated;
2. When the Covered Employee ceases to make the required contributions for the Dependent;
3. When the Covered Employee ceases to be in a class of employees eligible for Dependent Coverage;
4. When any Dependent ceases to meet the requirements of an Eligible Dependent, except as specified below and in the COVERAGE AFTER TERMINATION provision;
5. When such Dependent enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
6. When such Dependent becomes a Covered Employee;
7. When such Dependent ceases to maintain full-time residency in the United States of America or Canada, unless Employer assigned outside the U.S. or Canada; or
8. When Dependent Coverage is discontinued under This Plan.

Extended Coverage for Dependent Children

A child age twenty-six (26) and older who is physically handicapped or intellectually disabled may qualify for coverage beyond the age when other dependent coverage would end as long as ALL the following requirements are met:

1. The child is severely disabled by prolonged physical or mental incapacity;
2. The child became disabled prior to reaching age twenty-six (26);
3. The child was covered by The Plan prior to reaching age twenty-six (26), or, if older than age twenty-six (26), loses coverage under a parent's plan. In the event of loss of coverage, proof of coverage must be provided;
4. The child is unmarried and the Covered Employee provides more than 50% of his or her support because he or she is unable to earn a living due to intellectual disability or physical handicap.

For the dependent child to qualify, notice must be given to the Third Party Administrator within thirty-one (31) days after the date dependent coverage would normally end.

The extension of coverage will continue as long as the incapacity continues, the Covered Employee maintains dependent coverage, and This Plan remains in full force and effect. Proof of handicap may be required periodically.

Children who become disabled after age twenty-six (26) are not eligible for coverage

Coverage after Termination

Continuation of Coverage – Consolidated Omnibus Budget Reconciliation Act (COBRA)

(Plans with 20 or more employees)

A Covered Person whose coverage has been terminated for any qualifying event enumerated below has the right to continue coverage for all benefits of This Plan if covered for such benefits on the day immediately preceding the termination date. The time period for which the continuation is available is indicated on the following pages in conjunction with the corresponding qualifying event.

If Continuation of Coverage is elected, coverage will continue as though termination of employment or loss of eligible status had not occurred. Any accumulation of deductibles or benefits paid prior to termination or loss of eligibility, which had been credited toward any deductible or maximum benefit of This Plan, will be retained.

Also, no new or additional waiting period, or evidence of good health requirements will apply. If any changes are made to the coverage for employees in Active Service, the coverage provided to individuals under this continuation provision will be similarly modified.

Qualifying Events

An EIGHTEEN (18) MONTH continuation is available to Covered Employees and/or Covered Dependents if any one of the following qualifying events occurs:

1. A Covered Employee's termination of employment for any reason except gross misconduct; or
2. A Covered Employee's loss of eligibility to participate due to reduced work hours.

A TWENTY-NINE (29) MONTH continuation shall be available to all qualified beneficiaries if a Covered Person is disabled, per a determination under the Social Security Act, within sixty (60) days of the Covered Employee's termination of employment or reduction in work hours.

The Covered Person must provide the Plan Sponsor with notice of the disability within sixty (60) days of the determination of the disability by Social Security and before the end of the original eighteen (18) month COBRA coverage period. The Covered Person must notify the Plan Sponsor of a determination by Social Security that the individual is no longer disabled within thirty (30) days of such determination.

A THIRTY-SIX (36) MONTH continuation shall be available to a Covered Dependent spouse and/or child if any one of the following qualifying events occurs:

1. A Covered Employee's death;
2. Divorce or legal separation from a Covered Employee;
3. A Covered Dependent child's loss of eligibility to participate due to age; or
4. A Covered Dependent's loss of eligibility to participate in This Plan due to the Covered Employee becoming covered by Medicare as a result of Total Disability or choosing Medicare in place of This Plan at age sixty-five (65).

If any employee becomes covered by Medicare, but no loss of coverage results for the employee or the Covered Dependents, and a subsequent qualifying event occurs, the duration of coverage for all qualified beneficiaries other than the Covered Employee must be at least thirty-six (36) months from the date on which the employee became covered by Medicare.

Notice of Continuation

A Covered Person has at least sixty (60) days form the date of loss of coverage as a result of a qualifying event or sixty (60) days from the date the Plan Sponsor mails or otherwise provides the Covered Person with a notification of the Covered Person's rights pursuant to a qualifying event to elect coverage. Payment of initial premium is not required until the forty-fifth (45th) day after the election. All payments for coverage after the date of election are subject to a thirty (30) day grace period.

The Covered Person is required to notify the Plan Sponsor within sixty (60) days of any qualifying event of which it would not otherwise be aware, such as divorce, legal separation, or loss of dependent status by a dependent child.

The Covered Person is required to notify the Plan Sponsor with all information needed to meet its obligation of providing notice and continuing coverage.

Cost of Continuation

Contact the Mercer University Benefits Administrator or CHS for details regarding the cost of continuation under COBRA.

There may be other coverage options for each covered member. When key parts of the health care law take effect, a member will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, a member could be eligible for a new kind of tax credit that lowers their monthly premiums right away, and the member can see premiums, deductibles, and out-of-pocket costs before the member makes decision to enroll. Being eligible for COBRA does not limit a member's eligibility for coverage for a tax credit through the Marketplace. Additionally, a member may qualify for a special enrollment opportunity for another group health plan for which the member is eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if the member requests enrollment within 30 days.

Termination of Continuation of Coverage

Continuation of Coverage shall not be provided beyond whichever of the following dates is first to occur:

1. The date the maximum continuation period expires from the corresponding qualifying event;
2. The date This Plan is terminated;
3. The date the individual failed to make the required contribution to continue coverage;
4. The date the individual becomes covered under any other group health plan which does not contain any exclusion or limitation;
5. The date the individual becomes covered by Medicare (if the individual becomes covered by Medicare as a result of end stage renal disease, coverage will continue until the maximum continuation period expires for the corresponding qualifying event); or
6. In the month that begins more than thirty (30) days after a final determination has been made that an individual is no longer disabled.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA) under the following circumstances. The rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

1. The maximum period of coverage of a person and the person's Dependents under such an election shall be the lesser of:
    a. The twenty-four (24) month period beginning on the date on which the absence begins; or
    b. The day after the date on which the person was required to apply for or return to a position

2. A person who elects to continue health plan coverage must pay up to 102% of the full contribution under the Plan, except a person on active duty for thirty (30) days or less cannot be require to pay more than the Employee's share, if any, for the coverage.
3. An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed services.

In general, you must meet the same requirement for electing USSRRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

Instructions for Submission of Claims

Be sure the bills submitted include all of the following:

1. Employee's name, social security number and home address;
2. Patient's name, social security number and date of birth;
3. Employer'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 Plan for any loss other than loss for which This Plan 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 CHS or the Employer 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 Plan Description and Group Provisions pages.

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

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

Claim Provisions

Time Limit for Submitting Claims

Written proof of loss must be submitted within one (1) year of the date charges are incurred to be considered eligible for payment. Upon termination of the Employer's agreement with the Third Party Administrator (claims payer), written proof of loss must be submitted within ninety (90) days of the date the termination occurred to be considered eligible for payment. A charge will be deemed incurred on the date services are actually rendered or supplies are actually received.

If it was not reasonably possible to submit the claim in the time required, the claim will not be reduced or denied solely for this reason, if the claim is submitted as soon as reasonably possible. To be accepted, the claim must be submitted no later than one (1) year from the date of loss unless the Covered Person was legally incapacitated.

Right to Investigate Claims

The Plan Sponsor acting on their behalf retains the right to request any medical information from any provider of service it deems necessary to properly process a claim.

A Physician designated by the Plan Sponsor will have the right and opportunity to examine, at its expense, any person whose Illness or Injury is the basis for any claim, when and as often as reasonably required and, in the event of death, to make an autopsy, unless prohibited by law.

Claim Denial

In the event a claim is denied, in whole or in part, the Covered Person will be given written notice of the following:

1. The reason for denial;
2. Specific reference to Plan provisions on which the denial was based;
3. Any additional material or information needed for further review of the claim; and
4. An explanation of the review procedure.

Appeal

If a claim is denied, in whole or in part, the Covered Person may appeal the denial by making a written request to the Plan Sponsor for review within sixty (60) days after the denial is received. A Covered Person has the right to:

1. Review the Summary Plan Description, Group Provision Pages, and other papers affecting the claim (except information which a Physician does not wish to be made known to the claimant);
2. Argue against the denial in writing; and
3. Have a representative act on behalf of the Covered Person in the appeal.

Review

The decision on review shall be in writing and shall be made within sixty (60) days of the receipt of the request for review. The Plan Sponsor will have the final authority to determine participant and benefit eligibility under the terms of the Plan (but not under any stop-loss insurance contract). If the claim is denied upon review, the decision must include the following:

1. The specific reason for denial;
2. The decision must be written in a manner understandable to the Covered Person; and
3. The written denial will contain specific reference to the pertinent Plan provision upon which the decision was based.

Legal Actions

No action at law or in equity shall be brought to recover on This Plan prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of This Plan. No such action shall be brought after the expiration of three (3) years after the time written proof of loss is required to be furnished.

Coordination of Benefits

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

Coordination of Benefits Definitions

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

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

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

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

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

Order of Benefit Determination
When a claim is made, the primary plan pays its benefits without regard to any other plans.

The secondary plan adjusts its benefits so that the total benefits available will not exceed the Allowable Expense. No plan pays more that it would without the Coordination of Benefits Provision.

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

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

Recovery

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

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

Payment to Other Carriers

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

Release of Information

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

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

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

Effect of Medicare

THE FOLLOWING PROVISIONS APPLY TO THIS PLAN IF TWENTY (20) OR MORE EMPLOYEES ARE COVERED:

Active Employees and Spouses Age 65 and Older

When an Employee in Active Service who is age sixty-five (65) or older and when the Covered Dependent Spouse of any such Employee who is age sixty-five (65) or older becomes eligible for Medicare, the individual must choose one of the following options:

1. Primary coverage under This Plan (Under this option, benefits provided under This Plan will be paid without regard to Medicare); or
2. Sole coverage provided under Medicare (under this Option, coverage under This Plan will terminate).

If the individual does not choose one of the above options in writing, This Plan will be primary (option 1).

All Other Covered Persons Not in Active Service

For All Other Covered Persons who are not in Active Service and who are eligible for Medicare benefits under This Plan will be coordinated with the dollar amount that Medicare will pay.

A Covered Person who is eligible for Medicare will be considered to be covered for all benefits available under Medicare (Part A and Part B), regardless of whether or not the person has actually applied for Medicare coverage.

Your Prescription Drug Coverage and Medicare

On January 1, 2006, Medicare prescription drug coverage became available to everyone with Medicare. Your employer has determined that their plan's prescription drug coverage, on average and for all plan participants, is expected to pay out as much as the standard Medicare prescription drug coverage. Each year, prescription drug coverage is available to everyone with Medicare through a Medicare authorized prescription drug plan. All Medicare authorized prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because you have existing prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. People with Medicare will have the opportunity to enroll in a Medicare prescription drug plan annually between November 15th and December 31st of each year.

If you drop your employer's coverage and enroll in a Medicare prescription drug plan, you may not be able to get your employer's coverage back later. You should compare your current

coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.
In addition, your current employer sponsored health coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare Part D prescription drug program and maintain your employer's sponsored health coverage, you will still be eligible to receive all of your current health and prescription drug benefits.

You should also know that if you drop or lose your coverage with your employer and don't enroll in Medicare prescription drug coverage after your employer's coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go sixty-three (63) days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until the next November to enroll.

Disability Due to End Stage Renal Disease

If a Covered Person becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under This Plan, This Plan will pay its benefits first and Medicare will be the secondary payer for the first thirty (30) months of disability. After the initial thirty (30) months, Medicare will be the primary payer.

Plans with 100 or More Employees Covered

If a Covered Person becomes eligible for benefits under Medicare, as a result of a disability (other than End Stage Renal Disease) and chooses to remain Covered under This Plan, the benefits payable under This Plan will apply and This Plan will pay benefits first and Medicare will be the secondary payer.

For purposes of this provision, the term "disabled" will be the definition given by Social Security.

Special Enrollment Rights under CHIP

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

If you live in Georgia, you may be eligible for assistance paying your employer health plan premiums. You should contact your State for further information on eligibility –

GEORGIA – Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)
Phone: 1-800-869-1150

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Retirement Eligibility & Continuation of Coverage

Employees who retire from Mercer University may continue coverage under the Mercer Health Plan for themselves and/or those eligible Dependents covered at the time of retirement until the Retired Employee reaches the age of 65 years. Upon the Retired Employee attaining the age of 65 years, his/her coverage through Mercer will cease as he/he will be entitled to Medicare benefits. Any Dependents (under 65 years of age) covered at that time may elect to continue coverage under the Plan's COBRA Continuations. If the Employee retires at age 65 or greater, Retiree Coverage is not available.

Premium costs for Retiree Coverage for the employee (and any covered dependents) are fully paid by the Employee at the appropriate cobra rate.

Dependents carried under Employee Retiree Coverage are subject to the same terms of eligibility as those Dependents of Active Employees. Should a Dependent attain age 65 years before the Retired Employee, such Dependent will no longer be eligible for coverage under this Retiree provision.

A benefits-eligible employee is recognized as a retiree when the employee separates on good terms (not for cause), has indicated they are retiring from the University and meets the following requirements:

1. An employee with at least five years of benefits-eligible (75% FTE), a minimum age of 55 and whose age plus service is at least 70; or
2. An employee with at least five years of benefits-eligible (75% FTE), a minimum age of 55 and who has been granted disability retirement benefits from the University sponsored disability plan or full disability benefits through the Social Security Administration.

Subrogation

Immediately upon payment of any benefits under This Plan, This Plan shall be subrogated to all rights of recovery against any person or organization whose course of conduct or action caused, or contributed to the loss for which payment was made under This Plan.

The Covered Person and persons acting on his or her behalf shall do nothing to prejudice the Plan's subrogation rights and shall, when requested, provide the Plan with accident related information and cooperate with the Plan in the enforcement of its subrogation rights.

The Covered Person acknowledges that This Plan's Subrogation rights are a first priority claim against any potentially liable party to be paid before any other claim for the Covered Person's general damages, and This Plan shall be entitled to reimbursement even if the payments received by a Covered Person from a third party are insufficient to compensate a Covered Person in part or whole for all damages sustained.

For the purposes of this provision, a recovery which does not specify the matters covered shall be deemed to include a recovery for all expenses incurred to the extent of any actual loss due to the disability involved.

Rights of Recovery

In the event of any overpayment of benefits by This Plan, This Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of This Plan, the Covered Person will be requested to refund the overpayment. If the refund is not received from the Covered Person, recovery procedures will be initiated. Similarly, if payment is made on the behalf of a Covered Person to a Hospital, Physician, or other provider of health care, and that payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider.

ERISA Rights of Covered Employees

As a participant in This Plan, Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) as amended. ERISA provides that all Plan participants shall be entitled to:

1. Examine, without charge, at the Plan Sponsor's office and at other specified locations, such as worksites or union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

2. Obtain, upon written request to the Plan Sponsor, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Sponsor may make a reasonable charge for the copies.

3. Receive a summary of the Plan's annual financial report (if applicable). The Plan Sponsor is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of This Plan. The people who operate This Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA. If your claim for a benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the court may require the Plan Sponsor to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Sponsor.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Plan Document Definitions

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

Accidental Injury

Bodily Injury sustained by a Covered Person as the result of an unforeseen event and which is the direct cause (independent of disease, bodily infirmity, or any other cause) for care which the Covered Person receives.

Active Service

A Covered Employee will be considered in Active Service:

1. On a day which is a scheduled work day if the Covered Employee is:
    a. Performing in the customary manner all of the regular duties of the occupation on a full-time basis either at the customary place of employment or at some location to which travel is required; or
    b. Absent solely by reason of vacation; or
2. On a day which is not a scheduled work day only if the Covered Employee was performing in the customary manner all of the regular duties of the occupation on the last preceding scheduled work day.
3. If the Covered Employee is on approved leave of absence, sabbatical, or disability leave; or any Covered Employee who is active by the policies and procedures of Mercer University.

A Covered Dependent, other than a Newborn Child, will be considered in Active Service if on the day coverage would normally start, the Dependent is not confined for medical care or treatment (at home or elsewhere).

Allowable Expense

Any Medically Necessary expense incurred by a Covered Person which is covered at least in part under This Plan.

Alternative Treatment

In all cases in which there are optional treatments available which produce a professional satisfactory result, only the least costly alternative will be considered eligible under This Plan.

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.

Anesthesia Services

Anesthetics and their professional administration when ordered by the attending Physician or Dentist in connection with a Covered Procedure.

Annual Open Enrollment

The thirty (30) day period of time prior to the Plan Renewal Date in which all Eligible Employees may make changes to their Coverage by adding or deleting Coverage for themselves or their Dependents.

Assault or Illegal Occupation

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.

Birthing Center

A special room in a Hospital that exists to provide delivery and prenatal and post-natal care with minimum medical intervention, or a legally operated or licensed free-standing outpatient facility which:

1. Is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;
2. Has organized facilities for birth services on its premises;
3. Provides services which are performed by a Physician specializing in obstetrics and gynecology, or at the Physician's direction, are performed by a Certified Nurse Midwife;
4. Has 24 hour a day registered nursing services; and
5. Maintains daily clinical records.

Calendar Year

The twelve (12) month period of January 1 through December 31 inclusive.

Calendar Year Deductible

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

Calendar Year Maximum Per Person

The total amount payable for covered services incurred by a Covered Person during the Calendar Year.

Chemical Dependency / Alcoholism

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

Claim Determination Period

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

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).

Coinsurance

The Coinsurance for This Plan, per Calendar Year, is as follows: Coinsurance is the percent of a Covered Expense that The Plan pays after satisfaction of any applicable Deductible.

Complications of Pregnancy

Conditions with diagnosis distinct from pregnancy, but which may be caused by or be adversely affected by pregnancy. Complications include but are not limited to the following:

- Acute Nephritis
- Nephrosis
- Cardiac decompensation
- Missed Abortion Pre-eclampsia
- Intrauterine fetal growth retardation
- Cesarean section
- Termination of Ectopic pregnancy
- Similar medical and surgical conditions of comparable severity

Spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy stall NOT include:

- False Labor
- Morning sickness
- Occasional spotting
- Physician prescribed bed rest during the period of pregnancy
- Hyperemesis
- Gravidarum

Similar conditions associated with the management of a difficult pregnancy but 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.

Cosmetic Expenses

This Plan 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 and are Medically Necessary.

Covered Dependent

Any eligible dependent whose coverage became effective and has not terminated.

Covered Employee

Any eligible Employee whose coverage became effective and has not terminated.

Creditable Coverage

Creditable Coverage is the period of time that an individual has been covered by any of the following medical programs:

- The ERISA Plan in question;

- Another Group Health Plan;
- Non-Group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross type plans) or an HMO; Medicare (Part A or Part B);

- Medicaid;
- The Active Military Health Program;
- Tricare (benefit plan available for military families) formally called CHAMPUS;
- American Indian Health Care Programs;
- A State health benefits risk pool
- The Federal Employees Health Plan; A "public health plan"; or
- The Peace Corp Health Program.

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. Custodial Care may include but are not limited to the following:

1. Care provided when a patient no longer requires the use of Skilled Nursing Care, since the patient's condition has improved or stabilized sufficiently.
2. Care which is primarily protective or intended to help maintain a good level of personal hygiene and nutrition with help in the functions of daily living;
3. Care provided to patients who require long-term institutional care in a minimal care facility (not requiring Skilled Nursing Center).
4. Care creating conditions that are being controlled or supervised by structural behavioral modification programs or custodial milieu (controlled environmental situations);
5. The provision of room and board (with or without routine nursing care, training in personal hygiene, and other forms of self-care) and supervisory care by a Physician for a person who may or may not be mentally or physically disabled but whose care could have been adequately and safely provided on an outpatient basis; and
6. The provision of room and board (with or without routine nursing care, training in personal hygiene, and other forms of self-care) and supervisory care by a Physician for a person who may or may not be mentally or physically disabled and who is not under specific medical, surgical, or psychiatric treatment which is likely to reduce the disability or enable the patient to live outside an institution providing medical care.

Deductible

See Calendar Year Deductible.

Deductible Carry-Over Benefit

Expenses applied to one's deductible during the last three (3) months of any calendar year (where the participant was insured for the full year) also reduces the Calendar Year Deductible for the following year by that same amount.

Durable Medical Equipment

The least costly appropriate type of equipment prescribed by the attending Physician which:

1. Is Medically Necessary;
2. Is not primarily and customarily used for non-medical purposes (personal comfort, exercise or convenience);
3. Is designed for prolonged use (with the exception of consumable supplies);
4. Is for a specific therapeutic purpose in the treatment of an Illness or Injury; 5. Is not classified as laboratory equipment (e.g. glucose meters); and
6. Would have been covered if provided in a Hospital.

Employee Claim Incentive

The maximum award per occurrence is $500.

All employees are encouraged to review their dental bills for accuracy. If an error is discovered, this Plan will reimburse one-third (1/3) of the savings to the employee for the employee's diligence.

Employer

The Employer for This Plan is Mercer University. The company or any Participating Employers providing employment to the Covered Employee.

Employment Related Injury or Illness

This is NOT a Covered Expense under This Plan.

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 Workers' Compensation Law, Occupational Disease Law or similar legislation.

Excess of the Benefits Specified in This Plan

Charges not covered, or charges for Benefits not covered under This Plan.

Experimental or Investigational Services or Supplies

This is NOT a Covered Expense under This Plan.

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; 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 Federal

   Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or
3. 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 Plan

Charges for services or supplies rendered by the Employee, Employee's Spouse, or the Children, Brothers, Sisters, Parents, or Grandparents of either the Employee or the Employee's Spouse.

Fiduciary

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

Five-Year Rule

Charges for replacing an appliance or prosthetic device, such as a denture, crown, or bridge, will not be covered, unless it is at least five (5) years old and cannot be made usable.

Foreign Assignments

When temporarily assigned 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 Plan.

Foreign Travel

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

Government Owned / Operated Facility

This is not a Covered Expense under This Plan.

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.

Home Health Care

An agency or organization which provides a program of Home Health Care and is established and operated in accordance with the applicable laws in the jurisdiction licensed and approved by the regulatory authority having responsibility for licensing under the law.

Hospice Care

A program of care which provides pain free and alert existence for the terminally ill patient during the last months of life, while actively including the family in the care. The program can accomplish the above through inpatient care or home care, but emphasizes home care.

Hospital

An institution licensed as a Hospital and accredited by the Joint Commission on the Accreditation of Hospitals, American Osteopathic Association or Commission of Rehabilitative Facilities which:

1. Is primarily engaged in providing acute care and treatment of ill or injured persons on an inpatient basis;
2. Is under the supervision of one or more Physicians;
3. Maintains twenty-four (24) hour nursing service; and
4. Has organized facilities for laboratory and diagnostic work and major surgery.; and
5. Long Term Acute Care Facilities.

However, an institution specializing in the care and treatment of Mental / Nervous Conditions, which would qualify as a Hospital, except that it lacks organized facilities on its premises for major surgery, shall nevertheless be deemed a Hospital.

"Hospital" shall also include a residential treatment facility specializing in the care and treatment of Chemical Dependency / Alcoholism, provided such facility is duly licensed if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if licensing is not required.

In NO EVENT, however, shall "Hospital" include an institution which is (other than incidentally) a rest home, a nursing home, or a home for the aged, place for Custodial Care, educational facility, home for the handicapped, or a rehabilitative facility unless such rehabilitation is specifically for treatment of a physical disability.

Hospital Admissions

All Hospital Admissions must be Medically Necessary. See Pre-Certification and Concurrent Review Requirements.

Hospital Services

Personal comfort or incidental items such as telephones or televisions are excluded under This Plan. 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). 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. See also Pre-Certification and Concurrent Review Requirements.

Illness

Bodily disorder, infection or disease and all related symptoms and recurrent conditions resulting from the same causes and including Complications of Pregnancy.

Incapacitated Child Provision The child must be:

1. Unmarried and incapable of self-sustaining employment because of intellectual disability or physical disability; and
2. Be chiefly dependent on the employee for support; and 3. Charges are not a covered expense under a conversion policy.

To qualify for continued coverage under the Incapacitated Child provision, the child must meet specific requirements as defined in This Plan.

Injury

Physical harm sustained as the direct result of an accident, affected solely through external means and all related symptoms and recurrent conditions resulting from that same accident.

Intensive Care Unit

A section, ward or wing within the Hospital which is separated from other Hospital facilities, and:

1. Is operated exclusively for the purpose of providing professional care and treatment for critically ill patients;
2. Has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and

3. Provides room and board and constant observation and care by Registered Graduate Nurses (R.N.s) or other specially trained Hospital personnel;

Excluding any Hospital facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Medical Emergency

A severe Illness or Injury which:

1. Results in symptoms which occur suddenly and unexpectedly; and
2. Requires immediate Physician care to prevent death or serious impairment of the Covered Person's health.

Medically Necessary / Medical Necessity

Services and supplies which are determined by the Employer, or its authorized agent to:

1. Be appropriate and necessary for the symptoms and diagnosis and treatment of a medical condition;
2. Be in accordance with standards of good medical practice, within the organized medical community;
3. Not be solely for the convenience of the patient, Physician or other health care provider; and
4. Be the most appropriate supply or level of service which can be safely provided.

For hospitalizations, this means that acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's medical condition, and that safe and adequate medical care cannot be received as an outpatient or in a less intensified medical setting.

Just because the service is prescribed by a Physician does NOT mean the service is Medically Necessary. In an effort to make treatment convenient, to follow the wishes of the patient or the patient's family, to investigate the use of unproven treatment methods, or to comply with local Hospital practices, a Physician may suggest or permit a method of providing care that is not Medically Necessary.

Charges which are determined not to be Medically Necessary shall not be covered and no benefits will be payable for such charges. This will include, but is not limited to, services which are determined in a retrospective review and audit not to have been Medically Necessary.

Medicare

Part A and Part B of the insurance program established by Title XVIII, United States Social Security Act, as amended, 42 U.S.C. Sections 1394, et seq.

Mental/Nervous Condition

This includes, but is not limited to, psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality or mood disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neuro-hormonal systems and eating disorders such as anorexia and bulimia.

This is intended to include disorders, conditions and Illnesses listed in the Diagnostic and Statistical Manual of Mental Disorders.

No Legal Obligation to Pay

This is NOT a Covered Expense under This Plan.
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 Plan.
Treatment of an Injury or Illness that is not medically necessary. This includes charges for care, supplies or equipment.

Personal Hygiene

This is not a Covered Expense under This Plan.
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

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

Plan Sponsor

The person/organization responsible for the day-to-day functions and management of This Plan. The Plan Sponsor may employ persons or firms to process claims and perform other Plan connected services.

The Plan Sponsor is the named Plan Administrator within the meaning of Section 414(g) of the Internal Revenue Code of 1986, as amended, and is the named Administrator with the meaning of Section 3(16)(a) of the Employee Retirement Income Security Act of 1974 (ERISA), as amended.

The Plan Sponsor is:
The Corporation of Mercer University
1501 Mercer University Drive Macon,
GA 31207

Plan Year

The Plan Year for This Plan is July 1 through June 30.

The twelve (12) consecutive month period beginning on the Plan effective date and renewing on the same date each subsequent year.

Reasonable Charges

The most frequent charges which an individual Physician charges to the majority of patients for a given procedure. These charges must be within the range of fees charged by most Physicians of similar training and experience in a given geographical area for this same procedure, with consideration given to unusual circumstances involving medical complications requiring additional time, skill and experience.

Special Enrollee

An Eligible Employee or an Eligible Dependent who refused coverage at the time it was originally offered because he or she had other Creditable Coverage, but whose other Creditable Coverage has terminated due to exhausting COBRA Coverage or by losing eligibility due to certain specified reasons (e.g., divorce, death). In addition, a Special Enrollee includes new Dependents due to birth, adoption or marriage.

Special Enrollment Period

The thirty (30) day period of time surrounding a loss of other Coverage for a Special Enrollee, or the thirty (30) day period of time after a Dependent is acquired due to birth, adoption or marriage, during which a Special Enrollee may request Coverage under This Plan.

Third Party Administrator

The person/organization hired by the Plan sponsor in connection with the operation of This Plan 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 Plan / Plan

The Plan of benefits as contained in the Summary Plan Description and Group Provision Pages, and any agreements, schedules and amendments endorsed by the Employer, Participating Employer or Plan Sponsor.

Total Disability or Totally Disabled

A Covered Employee will be considered Totally Disabled during any period when the Employee is completely unable to perform the duties of the employee's occupation or work at any other gainful occupation. This definition is intended to correspond with Social Security's definition of Total Disability.

A Covered Dependent will be considered Totally Disabled during any period when, as a result of Injury or Illness, the Dependent is confined as a bed patient in a Hospital and is completely unable to engage in the normal activities of a person of the same age and gender.

War or acts of War

This is not a covered Expense under This Plan.
Declared or undeclared, including an Injury sustained or Illness contracted while on duty with any Military Service for any country.

Basic Group Term Life & Accidental Death & Dismemberment Insurance

Policy issued by: The Standard

Basic Life Insurance

The Mercer University Basic Life and Accidental Death and Dismemberment (AD&D) Insurance program is available to full time Mercer University employees. The cost of this insurance program will be paid by Mercer University.

IMPORTANT BENEFITS

One times annual earnings rounded to the next higher $1,000.00 will be provided at no cost to you.

The maximum amount of Basic Life and AD&D insurance is $50,000.

Effective Date of Coverage will be the 1st Day of Month following date of hire or eligibility.

Basic Life and AD&D coverage will reduce to 65% at age 70, to 42% at age 75, to 28% at age 80, to 18% at age 85, to 12% at age 90. An Active Employee's Basic and Optional Life Insurance terminates at the Employee's retirement, unless the Employee is eligible for Retiree Life Insurance.

Changes in the amount of Basic Life insurance due to changes in salary and/or changes due to your age will occur on the actual date of the salary and/or age change.

BECOMING INSURED

You must meet certain requirements to be eligible for Basic Life insurance. You must be a Member as defined in the basic Group Policy.

To become insured, you must meet the eligibility requirements and, if Basic coverage is elected after your original effective date, you must submit and have approved Evidence of Insurability

(Form G6000), and complete a new enrollment form. By completing the enrollment form, you are formally applying for the insurance.

You must have been Actively-at-Work on the effective date of your Basic Life coverage, or the effective date of your insurance coverage will be delayed.

OTHER IMPORTANT BENEFITS

If your Basic Life coverage ends or is reduced for any reason, you may have a right to buy an individual policy of whole life insurance without submitting Evidence of Insurability (during a 31day conversion period).

If eligible, you have the availability of continued Life insurance if Disability occurs before age 60.

WHEN INSURANCE ENDS

Your Basic Life and AD&D insurance will end on the earliest of the following dates:

a. The date your Basic Life and AD&D insurance ends or you are no longer a group member.
b. The date the basic Group Policy terminates, unless you qualify for Continued Life Insurance.
c. The last day of the last period for which the required contributions were made.
d. At your retirement.

ABOUT THIS OUTLINE

This outline is written in non-technical language and is not intended as a complete description of the coverage. The controlling provisions are in the Master Group Policy and the rider/amendments that provide Basic Life and AD&D Insurance; this outline does not modify those documents or the insurance in any way.

Supplemental Life Insurance

The Mercer University Supplemental Life Insurance program is available to full time Mercer University employees. You can now strengthen your financial security at affordable Group prices.

Policy issued by: The Standard

IMPORTANT BENEFITS

You apply for the amount* that is right for you and your family. You can select either:

1. One times basic earnings;
2. Two times basic annual earnings rounded to the next higher $1,000; or
3. $10,000 increments. Up to two times Supplemental Maximum. (Sup Max is $500,000)

AMOUNTS & COSTS

Your cost for each $1,000 of Supplemental Life is shown below and is based upon your age. The monthly premium will be paid through payroll deduction.

AGE	MONTHLY RATES/$1,000	EXAMPLE
34 & under	$0.10	
35-39	0.15	A 36-year-old Professor Crick makes $72,541.00 per year in eligible salary. He decides he needs two times basic annual earnings in supplemental term life insurance. He would pay:
40-44	0.20	
45-49	0.30	
50-54	0.44	
55-59	0.66	
60-64	1.04	Income Factor Rate/Month
65-69	1.96	$73,000 x 2 x .15/1,000 = $21.90
70-74	3.24	
75-79	5.60	

*Supplemental Life Coverage reduces Basic Life and AD&D coverage to 65% at age 70, to 42% at age 75, to 28% at age 80, to 18% at age 85, to 12% at age 90 and terminate at the Employee's retirement.

If you elect to increase the amount of your Supplemental Life insurance or if you apply for Supplemental Life insurance after your original effective date, you must provide satisfactory Evidence of Insurability and meet the Active-at-Work requirement before any change will become effective.

An insured's age nearest January 1 will determine the amount of premium.

BECOMING INSURED

You must meet certain requirements to be eligible for Supplemental Life. You must be (a) a Member as defined in the basic Group Policy, and (b) insured for Basic Group Life Insurance under that policy.

To become insured, you must meet the eligibility requirements and, if Supplemental coverage or a higher option of Supplemental coverage is elected after your original effective date, you must submit and have approved Evidence of Insurability (Form G6000), and complete a new enrollment form. By completing the enrollment form, you are formally applying for the insurance and authorizing any necessary payroll deductions to cover the cost of your Supplemental Life Insurance.

Your Supplemental Life Insurance becomes effective the 1st day of the month following eligibility, or if you applied for insurance after you were first eligible, your insurance becomes effective on the 1st day of the month following approval. You must be Actively-at-work on the effective date of your Supplemental Life coverage, or the effective date of your insurance coverage will be delayed.

OTHER IMPORTANT BENEFITS

If your Supplemental Life coverage ends or is reduced for any reason other than your failure to pay your premium, you may have a right to buy an individual policy of whole life insurance without submitting Evidence of Insurability (during a 31-day conversion period). If eligible, you have the availability of continued Life insurance if Disability occurs before age 60.

WHEN INSURANCE ENDS

Your Supplemental Life Insurance will end on the earliest of the following dates:

a. The date your Basic Life insurance ends or you are no longer a group member.
b. The date the basic Group Policy terminates, unless you qualify for Continued Life Insurance.
c. The last day of the last period for which you made the required contribution for your Supplemental Life Insurance.
d. At retirement of the employee.

ABOUT THIS OUTLINE

This description is written in non-technical language and is not intended as a complete description of the coverage. The controlling provisions are in the Master Group Policy and the rider/amendment that provides Supplemental Life Insurance, and this brochure does not modify those documents or the insurance in any way.

"GRAND-FATHERED" LIFE AND A. D. & D. INSURANCE

The Mercer University "Grand-fathered" Life and AD&D Insurance program is available only to those full-time Mercer University employees who elected this coverage in January 1995. This coverage is in addition to the Basic Life and AD&D and Supplemental Life insurance program. The insurance amount under this plan is the amount of insurance for which the employee was previously insured prior to December 14, 1994 (employed on or before 12/14/94), minus the amount of insurance for

which the employee is covered under the Mercer University Basic Life and AD&D Insurance program.

This insurance will not increase or decrease as the individual's salary changes.

This insurance program is not available to anyone who was not already insured under the prior Life Insurance plan.

AMOUNTS AND COSTS

The cost for each $1,000 of "Grand-fathered" Life coverage is $.22 per thousand dollars per month for the Life coverage and $.03 per thousand dollars per month for the AD&D coverage. The monthly premium is paid through payroll deduction.

Example: Professor Jones makes $72,541.00 per year in eligible salary. She was previously insured under the prior insurance plan for two times basic annual earnings ($145,082), rounded to the next higher $1,000, which would have been $146,000. She would pay:

"Grandfathered" - Basic		
Annual Income Factor Two Times	**Income Rounded Amount Less BAE Maximum**	**Amount**
$72,541 x 2 = $145,082	$146,000 - $50,000*	$96,000

"Grandfathered" - Monthly Premium

Life Rate AD&D Rate Amount /1,000 Premium $ .22 + $.03 = $ .25 x 96 = $24.00

*Basic schedule 1 x BAE maximum $50,000.

"Grand-fathered" Life and AD&D coverage will reduce to 65% at age 70, to 42% at age 75, to 28% at age 80, to 18% at age 85, to 12% at age 90 and terminate at the Employee's retirement.

OTHER IMPORTANT BENEFITS

If your "Grandfathered" Life coverage ends or is reduced for any reason other than your failure to pay your premium, you may have a right to buy an individual policy of whole life insurance without submitting Evidence of Insurability (during a 31-day conversion period).

If eligible, you have the availability of continued Life insurance if Disability occurs before age 60.

WHEN INSURANCE ENDS

Your "Grandfathered" Life and AD&D Insurance will end on the earliest of the following dates:

a. The date your Basic Life and AD&D insurance ends or you are no longer a group member.
b. The date the basic Group Policy terminates, unless you qualify for Continued Life Insurance.

c. The last day of the last period for which you made the required contribution for your "Grandfathered" Life and AD&D Insurance.
d. At retirement of the employee.

ABOUT THIS OUTLINE

This outline is written in non-technical language and is not intended as a complete description of the coverage. The controlling provisions are in the Master Group Life and AD&D Policy and the rider/amendment that provides "Grandfathered" Life and AD&D Insurance, and this outline does not modify those documents or the insurance in any way.

Dependent Life Insurance

The Mercer University Dependent Life Insurance program is available to full time Mercer University employees. You can strengthen your own and your family's financial security at affordable Group prices.

Policy issued by: The Standard

IMPORTANT BENEFITS

The Dependent Life unit schedule will be:

CLASSIFICATION	BENEFIT
Spouse	$10,000
Dependent Children:	
6 months to age 23, 25 if student	$10,000
10 days to 6 months	$1,000

The maximum amount of Dependent Life insurance is 50% of the employee Basic Life insurance.

AMOUNTS AND COSTS

Your unit cost will be $2.66 per month. The monthly premium will be paid through payroll deduction, and can only be paid on an After-Tax basis.

Coverage terminates at age 70 of the spouse or at retirement of the employee.

If you apply for Dependent Life insurance after your original effective date, your dependents must provide satisfactory Evidence of Insurability and not be hospital confined. You must meet the Active-at-Work requirement before the Dependent Life insurance becomes effective.

BECOMING INSURED

You must meet certain requirements to be eligible for Dependent Life. You must be:

a. A Member as defined in the basic Group Policy, and
b. Insured for Basic Group Life Insurance under that policy.

To become insured, you must meet the eligibility requirements and complete a new enrollment form. By completing the enrollment form, you are formally applying for the insurance and authorizing any necessary payroll deductions to cover the cost of your Dependent Life Insurance.

Your Dependent Life Insurance becomes effective the 1st day of the month following eligibility, or if you applied for insurance after you were first eligible, your insurance becomes effective on the

1st day of the month following approval. You must be Actively-at-work on the effective date of your Dependent Life coverage, and your dependents must not be hospital confined, or the effective date of your insurance coverage will be delayed.

OTHER IMPORTANT BENEFITS

In the event an employee insured for employee Group Life Insurance dies or terminates employment, the amount of Dependent Life Insurance on the surviving spouse and children may be converted to individual policies.

WHEN INSURANCE ENDS

Your Dependent Life Insurance will end on the earliest of the following dates:

a. The date your Basic Life insurance ends or you are no longer a group member.
b. The date the policy terminates.
c. The last day of the last period for which you made the required contribution for your Dependent Life Insurance.
d. At age 70 of the spouse or at retirement of the employee.

ABOUT THIS OUTLINE

This outline is written in non-technical language and is not intended as a complete description of the coverage. The controlling provisions are in the Master Group Life and AD&D Policy and the rider/amendment that provides Dependent Life Insurance, and this brochure does not modify those documents or the insurance in any way.

Cancer Insurance

Available to Regular Full-Time Employees

Mercer offers the option of purchasing a Cancer Insurance Policy to offer you and your family supplemental protection in the event you are diagnosed with Cancer, including Leukemia & Hodgkin's Disease. Coverage is provided through American Family Life Assurance Company of Columbus (AFLAC).

Policy issued by: AMERICAN FAMILY LIFE ASSURANCE COMPANY OF COLUMBUS (AFLAC)

Worldwide Headquarters: 1932 WYNNTON ROAD, COLUMBUS, GEORGIA 31999 TOLL-FREE 1-800-99-AFLAC (1-800-992-3522)

Effective Date of Coverage

1st Day of Month Following Date of Approval by AFLAC

Benefits Include

Please refer to the Outline of Coverage as provided by the Benefits Office.

Policy Rates

Monthly rates vary based on age and when grandfathered, the date the policy was purchased.

Employee Only
One Parent Family (Employee and child)
Two Parent Family (Employee, spouse and/or children)

The policy provides supplemental coverage only and may be issued only to employees who have supplement insurance already in force. An outline of coverage may be requested by contacting the Benefits Office.

Group Long Term Disability Insurance Certificate

Available to Regular Full-Time Employees

Mercer provides Long Term Disability coverage for benefit eligible faculty and staff which will provide you income should you become disabled. Generally, the policy pays a monthly income benefit equal to 60% of your monthly wage base, less the sum of benefits from any other income sources, during your period of disability. Coverage is provided through The Standard Insurance Company.

Effective Date of Coverage

1st Day of Month after 1 Year of continuous Service

Some Waivers Apply

Disability Benefits Start

1st Day of Month after 6 Months of continuous Disability

Your Monthly Cost

Mercer pays 100% of Premium

CARRIER:	The Standard Insurance Company 900 SW Fifth Avenue Portland, OR 97204-1235
EMPLOYER:	Mercer University
POLICY NUMBER:	135883-A

The benefits described in this certificate apply to a term of Disability beginning on or after January 1, 2001.

The Table of Contents on the next page will help you locate important items, such as the date you become eligible, the benefits, and definitions of terms.

PLEASE READ THE ENTIRE CERTIFICATE. IT IS IMPORTANT.

This certificate details the main features of the insurance provided under the group policy issued to The Standard Insurance Company. Subject to the terms and conditions of the group policy, you are insured for the benefits described in this certificate. Your insurance will take effect only if you are eligible for insurance and become, and remain insured under the group policy.

This certificate replaces any other certificates that may have been previously issued to you describing this insurance.

PART 1

LONG TERM DISABILITY INSURANCE AT A GLANCE

PART 1 is a brief outline of this plan. Please be sure to READ THE ENTIRE CERTIFICATE for complete details.

ELIGIBILITY

Eligible Class(s)

All full-time permanent Employees including Employees of Georgia Baptist College of Nursing

Work Test

An Employee must work at least 30 hours a week to be considered a full-time Employee.

Except that if you are an otherwise eligible faculty member, you will not become ineligible for insurance by reason of a reduction in your work schedule due to your participation in your Employer's Phased Retirement Incentive program.

Waiting Period

For All Eligible Employees 1 year of service in an eligible class

BENEFITS

Benefits Start:

As of the first day of the month after the end of the Elimination Period--The Elimination Period is the longer of:

(A) 6 months of continuous Disability; or
(B) any period you are eligible to receive payments in each calendar month equal to your full Monthly Wage Base under your Employer's short term disability plan (whether insured or not insured), or under your Employer's sick leave or salary continuation program.

Benefits Continue:

...during a term of continuous Disability until the following age or time limit:

Age When Disability Starts	Length of Benefits Paid
Less than 60 yrs. of age	to age 65
60 but less than 65 yrs. of age	5 years (up to 5 years)
65 but less than 68 1/2 yrs. of age	to age 70
68 1/2 or over yrs. of age	1 year

Except, no benefits will be payable for more than 24 months if Disability is due to Mental Illness, alcoholism and/or drug abuse.

Benefit Types and Amounts:

(A) The Monthly Income Benefit

...equals 60% of your Monthly Wage Base not to exceed a benefit of $7,500 per month, less the sum of the Benefits from Other Sources (see PART 8: DEFINITIONS) that apply to the same month.
In no event will the Minimum Monthly Income Benefit be less than $100; or if greater, 10% of the Monthly Income Benefit before Benefits from Other Sources are subtracted.

If Monthly Earnings While Disabled exceed 20% of the Increasing Monthly Wage Base, this benefit may be adjusted.

(B) The Monthly Annuity Premium Benefit

...is equal to a percentage of your Monthly Wage Base as determined by your classification as follows:

If You Are an Eligible Employee and You Were Hired Prior To January 1, 1993, and Are Participating In the Mercer University Retirement Plan

The Monthly Annuity Premium Benefit is determined by your years of service as follows:

Years of Credited Service	**Monthly Annuity Premium Benefit**
2 years or less	0%
Over 2 years	10%

If You Are an Eligible Employee and You Were Hired On or After January 1, 1993, and Are Participating In the Mercer University Retirement Plan

The Monthly Annuity Premium Benefit is determined by your years of credited service as follows:

Years Of Credited Service	**Monthly Annuity Premium Benefit**
2 Years or less	0%
Over 2 through 7 years	6%
Over 7 years	10%

If Monthly Earnings While Disabled exceed 20% of the Increasing Monthly Wage Base, this benefit may be adjusted.

(C) The Annual Benefit Adjustment

...adjusts the Monthly Income Benefit and the Monthly Annuity Premium Benefit. The first adjustment will take effect 36 months after the date Standard benefits are first payable for a term of Disability. The adjustment will reflect the percentage change in the U.S. Consumer Price Index but will never be greater than 3%.

(D) The Survivor Income Benefit

...equals the last Monthly Income Benefit you received, multiplied by 3. It will be paid to your Surviving Dependent(s) if you had been disabled for at least 12 months.

OTHER FEATURES INCLUDE

1. Rehabilitation Service
2. Social Security Disability Assistance
3. Work Transition Period
4. Eligibility when you are Re-hired

DEFINITION AMOUNTS

Increasing Monthly Wage Base Percentage ...equals
3%.

DISABILITIES NOT COVERED
No Benefits will be paid
...if the Disability is caused, or contributed to, by:

1. An intentionally self-inflicted injury;
2. War;
3. Taking part in a felony;
4. Riot; or

...for Disability:

1. while you are in prison.

PART 2

ELIGIBILITY

To Be Eligible For Insurance
...you must be in an eligible class and meet any required Work Test shown in PART 1.

You Will Become Eligible for Insurance
...on the first day of the month that falls on or next follows the date you complete the required Waiting Period shown in PART 1 for your eligible class. However, if you were insured under a prior employer's group Long Term Disability insurance policy, you will become eligible for insurance on the first day of the month that falls on or next follows the date you enter an eligible class, if:

(a) the prior policy provided income benefits for 5 or more years of Disability; and
(b) you were insured under the prior policy within 3 months before the date you entered the eligible class;

provided you are Actively at Work on the date you become eligible. If you are not actively at Work on that date, you will become eligible on the date after you have completed 5 full consecutive days of Active Work.

If You Are Rehired
...within 1 year of the date employment ceased you will become eligible for insurance on:

(1) the date of your re-entry into an eligible class, if you were previously insured under the policy; or
(2) the date you become eligible for insurance as set forth in "You Will Become Eligible for Insurance" above, if you were not previously insured under the policy. All full months of service in an eligible class prior to the date employment ceased will be used in determining this date.

You must be actively at Work on the date you are to become eligible. If you are not actively at Work on that date, you will become eligible on the date after you have completed 5 full consecutive days of Active Work. If you are a rehired Employee, your most recent effective date of insurance will be used throughout this certificate as the date you became insured.

To Become Insured
...you must be an eligible Employee.

You Will Become Insured
...on the date you become eligible.

The Cost for the Insurance ...is
paid by your Employer.

The day before each plan anniversary (see "PART 9: ERISA") marks the end of the plan year. Generally near the end of the plan year, Standard reviews the plan and the premiums being charged. If a premium change is to be made, Standard will notify your Employer.

PART 3

DISABILITY BENEFITS

(WHEN BENEFITS START AND DURATION OF BENEFITS)

Benefits Will Be Payable
...as of the first day of the month after the end of the Elimination Period shown for when Benefits Start in PART 1, if the following conditions are met:

(1) Disability starts while you are insured under the group policy; and
(2) Disability does not result from any cause listed in "PART 4: DISABILITIES NOT COVERED"; and
(3) Notice of Claim and Proof of Disability are given to Standard as set forth in "PART 7: GENERAL PROVISIONS"; and

(4) For payment of the Monthly Annuity Premium Benefit, the conditions set forth in "PART 3: TYPES OF BENEFITS (B)" are met.

However, if you:

(1) return to Active Work for your Employer before benefits are payable; and
(2) become Disabled again from the same or related cause within 90 days of your return to Active Work;

the term of Disability will be considered continuous. Any days of Active Work, however, will not count toward meeting the Elimination Period. This paragraph will not apply if you return to Active Work after the date the policy terminates.

No benefits will be payable for the Elimination Period shown in PART 1 for when Benefits Start.

After Benefits Start, They Will Continue To Be Payable

...each month during your term of continuous Disability. The last benefit payment will be made as of the first day of the month in which the earliest of these events occurs:

(1) You are no longer Disabled; or
(2) You reach a limit shown under "Benefits Continue" in PART 1; or
(3) You attain one of the time limits in (A) or (B) below, if Disability is due to Mental Illness, alcoholism and/or drug abuse. The time limits are:

(A) the number of months of benefits shown in PART 1 for Mental Illness, alcoholism and/or drug abuse under "Benefits Continue". Except, if at the end of that period you are confined to a Hospital or Institution, benefits will continue to be payable for the remainder of the confinement. Upon discharge:

(1) benefits will continue to be payable for 3 months, if you continue to be Disabled; and
(2) if during the 3 month period in (1) above, you are re-confined to a Hospital or Institution for at least 14 consecutive days, benefits will continue to be payable during the re-confinement and for an additional 3 months following your discharge; or

(B) the number of months of benefits shown in PART 1 for Mental Illness, alcoholism and/or drug abuse under "Benefits Continue". Except, if at the end of that period you continue to be Disabled and are later confined to a Hospital or Institution for at least 14 consecutive days, benefits will be payable during the confinement period. One month of benefits will be paid for a confinement period lasting more than 14 consecutive days but less than a complete month.

Upon attaining the time limits in (A) or (B) above, no further benefits are payable for any Disability due to Mental Illness, alcoholism and/or drug abuse until after you:

(1) have returned to Active Work for your Employer; and

(2) were insured in a class of Employees eligible for insurance; and

(3) were fully performing the duties of your regular occupation for at least 6 continuous months.

Recurrent Disability

If, after benefits cease because you are no longer Disabled, you:

(1) return to Active Work for your Employer; and

(2) become Disabled again from the same or related cause within 12 months after the date benefits ceased; benefits will begin as of the first day of the month after Disability starts.

Benefits payable during a term of recurrent Disability will be based on the provisions and Monthly Wage Base that applied to the prior term of Disability. This provision will not apply to you if you become Disabled after the group policy terminates, nor will it apply to you if while receiving benefits you also attain a limit shown under "Benefits Continue" in PART 1.

TYPES OF BENEFITS

(A) The Monthly Income Benefit
...is equal to the amount shown in PART 1.

(In the case of the last benefit payment, The Standard Insurance Company will use the amount of Benefits from Other Sources that applied to the prior month.) Benefits from Other Sources are set forth in detail in "PART 8:

DEFINITIONS:

If your Monthly Earnings While Disabled are 20% or less of your Increasing Monthly Wage Base, no change will be made to the amount of the Monthly Income Benefit.

If your Monthly Earnings While Disabled are more than 20% of your Increasing Monthly Wage Base, a Work Transition Period of 12 months will be provided. During the **Work Transition Period**, no change will be made to the Monthly Income Benefit as shown in PART 1, except to stay within the 100% limit stated below. In no event will the Work Transition Period exceed the first 12 months of benefits for you during your lifetime.

After the Work Transition Period, a **percentage of the Monthly Income Benefit** is payable. The percentage is obtained by dividing Lost Income by the Increasing Monthly Wage Base. That percentage is then applied as the multiplier to the amount of the Monthly Income Benefit. As any changes occur in your Monthly Earnings While Disabled, Increasing Monthly Wage Base, or Monthly Income Benefit, the amount of benefits payable by The Standard Insurance Company on or after the date of the change will be adjusted to reflect the change.

If at any time, including during the Work Transition Period, the Monthly Income Benefit plus the combined monthly amount of Benefits from Other Sources and Monthly Earnings While Disabled exceed 100% of your Increasing Monthly Wage Base, the **Monthly Income Benefit will be adjusted**. When the adjustment is made, the Monthly Income Benefit plus the combined monthly amount of Benefits from Other Sources and Monthly Earnings While Disabled will equal 100% of your Increasing Monthly Wage Base.

In no event will the Monthly Income Benefit be less than the **Minimum Monthly Income Benefit** shown in PART 1.

Payment of the Monthly Income Benefit
This benefit is payable by The Standard Insurance Company to you as of the first day of each month. Payment is subject to The Standard Insurance Company's right to receive proof of continued Disability. The Standard Insurance Company reserves the right to pay any Monthly Income Benefit to any person as trustee for you if the trustee is a person by whom or an institution in which you are being maintained. Before payment is made to any person as trustee, The Standard Insurance Company must be satisfied that you are not able, for physical or mental reasons, to accept the payment. Such payment will discharge The Standard Insurance Company's obligation for that payment The Standard Insurance Company will not be liable for the acts or neglects of any trustee to whom payment is made.

(B) The Monthly Annuity Premium Benefit ...is
determined as shown in PART 1.

This benefit will be credited to TIAA and College Retirement Equities Fund (CREF) annuities for you:

(1) if you were participating in your Employer's retirement plan at the start of Disability; and
(2) as long as you do not elect, at any time during your Disability, the full benefit payable from the TIAA Retirement Annuity Contract or CREF Retirement Unit-Annuity Certificate under any option available.

If your Monthly Earnings While Disabled are 20% or less of your Increasing Monthly Wage Base, no change will be made to the amount of the Monthly Annuity Premium Benefit.

If your Monthly Earnings While Disabled are more than 20% of your Increasing Monthly Wage Base, a **Work Transition Period** of 12 months will be provided. During the Work Transition Period, no change will be made to the Monthly Annuity Premium Benefit. In no event will the Work Transition Period exceed the first 12 months of benefits for you during your lifetime.

After the Work Transition Period, a **percentage of the Monthly Annuity Premium Benefit** is payable. The percentage is obtained by dividing Lost Income by the Increasing Monthly Wage Base. That percentage is then applied as the multiplier to the amount of the Monthly Annuity

Premium Benefit. As any changes occur in your Monthly Earnings While Disabled, Increasing Monthly Wage Base, or Monthly Annuity Premium Benefit, the amount of benefits payable by TIAA on or after the date of the change will be adjusted to reflect the change.

The Monthly Annuity Premium Benefit does not apply to TIAA-CREF Supplemental Retirement Annuities (SRAs) or to premiums paid to them.

Payment of the Monthly Annuity Premium Benefit

This benefit is not payable directly to you. It will be paid by The Standard Insurance Company as of the first day of each month to be credited to a TIAA Retirement Annuity Contract and/or a CREF Retirement Unit-Annuity Certificate for you. Any payment made to such TIAA and/or CREF annuity will be divided according to any option available at the time the payment is made. No payment will be made before the date The Standard Insurance Company receives and approves a completed application for the contract or certificate unless you already own such a contract or certificate. Except, if during a term of Disability you elect a benefit from such TIAA or CREF annuity, The Standard Insurance Company will not accept an application for another contract or certificate. Payment is subject to The Standard Insurance Company's right to receive proof of continued Disability.

(C) The Annual Benefit Adjustment

...will adjust the Monthly Income Benefit and the Monthly Annuity Premium Benefit. The first adjustment will take effect as of the time shown in PART 1. Future adjustments will take effect on the first day of the same month each calendar year (January 1 - December 31) thereafter as long as benefits continue to be payable.

In each calendar year, the amount of the adjustment will reflect the percentage change in the U.S. Consumer Price Index - All Urban Consumers (CPI) for the 12 month period ending on the June 30th prior to the start of the calendar year. In no event will the amount of the adjustment be greater than the percentage limit shown in PART 1. Nor will the adjusted benefit be less than the amount that would have been payable if this provision did not apply.

(D) The Survivor Income Benefit

...is determined as shown in PART 1.

The Survivor Income Benefit is payable as of the first day of the month after your death if you:

(1) had been Disabled for the full 12 months prior to your death; and
(2) are survived by one or more Surviving Dependents.

A Surviving Dependent

...is your:

(1) spouse; or
(2) unmarried child who was dependent on you for support and maintenance and who is:

(a) less than 19 years of age; or
(b) 19 but less than 23 years of age and enrolled in a school as a full-time student.

The term “child” will include your adopted child or step child.

Payment of the Survivor Income Benefit

This benefit is payable by The Standard Insurance Company as of the first day of the month after your death. Your Surviving Dependent spouse, if living, will receive the full benefit; otherwise, the benefit will be paid in equal shares to all your Surviving Dependent children. If this benefit is payable to your Surviving Dependent children, The Standard Insurance Company reserves the right to pay the benefit to a person or persons whom The Standard Insurance Company is satisfied should receive the benefit on the children’s behalf. Such payment will discharge The Standard Insurance Company’s obligation for that payment. The Standard Insurance Company will not be liable for the acts or neglects of any person or persons to whom payment is made.

Proof of your death will be required before the Survivor Income Benefit is paid. The Standard Insurance Company may also require proof that a dependent is a Surviving Dependent. All proof must be satisfactory to TIAA.

TYPES OF SERVICES

Rehabilitation Service

Rehabilitation services are services that The Standard Insurance Company determines prepare you to work to the fullest extent of your ability. The Standard Insurance Company will give you a written statement of the services, and their extent. The services may include but are not limited to the following:

(1) vocational testing;
(2) job preparation;
(3) career counseling;
(4) retraining; and
(5) work place modification.

Social Security Disability Assistance

The Standard Insurance Company can help you to apply for Social Security Disability Benefits.

The Standard Insurance Company may also help you appeal a denied application for such benefits.

This service will be provided at no cost to you or your Employer.

No Benefits Will Be Paid

...if Disability is caused, or contributed to, by:
(1) an injury or a sickness that is intentionally self-inflicted; or

(2) an injury or a sickness that results from war, declared or not declared; or
(3) an injury or a sickness that results from taking part in a felony; or
(4) an injury or sickness that results from any active participation in a riot.

Nor Will Benefits Be Payable:

(1) while you are confined in a prison or other correctional facility, or in a treatment facility in lieu of being confined in any correctional facility.

PART 5

WHEN INSURANCE CEASES

Your Insurance Will Cease

...on the earliest of the following events:

(1) the date the group policy terminates; or

(2) the date the group policy is changed to terminate insurance on the class of Employees to which you belong; or
(3) the date you stop Active Work in an eligible class; or
(4) the date that ends the period for which you made the last required premium contribution, if any.

If you are no longer actively at Work due to a leave of absence or a Disability, ask your Plan Administrator when your insurance ceases.
Your Plan Administrator is listed in "PART 9: ERISA".

If your insurance ceases, it will not affect your benefits for a Disability existing on that date.

PART 6

REQUESTING INFORMATION AND APPLYING FOR BENEFITS

Requesting Information

The Plan Administrator will answer any written question or request that you have about enrollment, participation or other administrative matters. You will receive a written explanation within a reasonable period of time (not more than 90 days after the Plan Administrator receives your written question or request).

If your request is denied, the explanation will include the reasons for the denial, a description of any materials necessary to complete the request, and an explanation of why this material is necessary. And, it will tell you how to apply for a review if you are not satisfied with the explanation.

(A) Applying for Review

If your request is denied or you are not satisfied with the response, you may ask for a review. Write directly to the Plan Administrator within 60 days of receiving your answer. You or your duly authorized representative may examine any documents pertaining to your question or request. You are encouraged to submit issues and comments to the Plan Administrator. You will receive a decision in writing on the review within a reasonable time (not more than 60 days).

(B) Delays

If special circumstances require a delay on a request or question, the Plan Administrator will notify you. The notice will explain reasons for the delay and when you can expect a decision. If it is a delay on the initial request or question, the Plan Administrator will inform you not more than 90 days after the day the request was submitted and will send a decision not more than 90 days after the notice of the delay. If the delay is on a request for review, the Plan Administrator will notify you of the delay not more than 60 days after the request date and will send a decision not more than 60 days after the notice.

(C) Service of Legal Process

Service of legal process on any administrative matter should be directed to the Plan Administrator.

Applying for Benefits

When you anticipate that your Disability will extend beyond the end of the Elimination Period shown in PART 1, you should request an application for benefits. The Plan Administrator can supply the application and help you complete it. You should also apply for Social Security disability benefits and any Workers' Compensation benefits at the same time. When an application for benefits is received The Standard Insurance Company will process it promptly.

(A) Time Limits

Time limits for sending the application for benefits can be found in this certificate in "PART 7: GENERAL PROVISIONS."

(B) Denied Application for Benefits

If The Standard Insurance Company denies an application for benefits, you will receive a written denial within a reasonable period of time (not more than 90 days). The Standard Insurance Company will specify the reason(s) for the denial, the provisions of the contract on which the denial is based, and how to ask for a review.

When appropriate, The Standard Insurance Company's letter will also describe any material which might complete or perfect the application and will explain why the material is needed.

(C) Asking for a Review

You may ask for a review of a denied application for benefits by writing directly to The Standard Insurance Company within 60 days of receiving the denial. You or your duly authorized representative may examine documents pertaining to your application. You are encouraged to submit issues and comments to The Standard Insurance Company. You will receive a decision of the review within a reasonable period of time (not more than 60 days).

(D) Delays

If special circumstances require a delay in evaluating an application for benefits, The Standard Insurance Company will notify you. The notice will explain the reason for the delay and when a decision can be expected.

If it is a delay on an initial application, The Standard Insurance Company will notify you not more than 90 days after the day the application was submitted and will send a decision not more than 90 days after the notice of delay. If the delay is on a request for review of a denied application for benefits, The Standard Insurance Company will notify you of the delay not more than 60 days after the request date and will send a decision not more than 60 days after the notice.

The Standard Insurance Company will comply with any shorter time limits which may be required by the laws or regulations of the state in which the group policy is issued.

Requests for Information about Your Insurance

Please direct any written request for information about The Standard Insurance Company's Long Term Disability Benefits policy, its terms, conditions, interpretations, application for benefits there under, review of an application, and the service of legal process to: The Standard Insurance Company, 900 SW Fifth Avenue, Portland, OR 97204-1235.

PART 7

GENERAL PROVISIONS

Notice of Claim, Proof of Disability and Other Proofs

The Standard Insurance Company must receive in writing both notice of claim and proof of Disability within 12 months after the start of Disability.

(A) Written Proof

Forms for filing proof will be sent to you or to your Employer when The Standard Insurance Company receives written notice of a claim. If forms are not sent within 10 working days after The Standard Insurance Company receipt of notice, you will be deemed to have met the group policy's condition for filing proof by submitting in writing, within the required 12 months, proof of the occurrence, character and extent of the Disability. Written proof of continued Disability is required at reasonable intervals to be determined by The Standard Insurance Company. All proof must be satisfactory to The Standard Insurance Company.
Notice of Claim, Proof of Disability and Other Proofs (A) Written Proof

(B) Delays in Giving Notice or Proof

No claim will be denied or reduced if it is shown that it was not reasonably possible for you to give notice of claim or proof of Disability at the time it was required and such notice or proof is given as soon as reasonably possible.

(C) Types of Proof

The Standard Insurance Company may require as part of the proof of Disability: statements of treating physicians; copies of test reports or examinations; x-rays; hospital records; medical examinations by impartial specialists at The Standard Insurance Company's

expense; investigations conducted by The Standard Insurance Company or outside agencies The Standard Insurance Company will have the right and the chance to examine you at such times as it may reasonably require during the time a claim is pending.

(D) Other Proofs

Other proofs that The Standard Insurance Company may require are: sufficient evidence that you have applied for all of the Benefits From Other Sources; and prompt receipt of all written benefit decisions made by the providers of the Benefits From Other Sources; employment records, financial records, including copies of tax returns for you and for any business in which you participate as a principal; and any other information The Standard Insurance Company may reasonably require to determine benefits payable. The Standard Insurance Company may also require records that are in your Employer's control or custody, and may require one or more interviews with you.

Time of Payment of Claim

Subject to the proof of Disability and, if benefits are payable to someone other than you, the conclusive identification of the person to whom benefits are to be paid, all accrued benefits payable under the group policy will be paid not later than the end of each period of 30 days during the continuance of the period for which The Standard Insurance Company is liable. Any balance unpaid at the termination of Disability will be paid immediately upon receipt of such proof. The Standard Insurance Company will pay interest equal to 18% per annum on the benefits due under the terms of the group policy for failure to comply with these requirements.

Overpayment of Benefits

Any overpayment of benefits must be repaid to The Standard Insurance Company. To recoup the amount overpaid, The Standard Insurance Company at its option will:

(1) require that the amount be repaid by you or your Surviving Dependents to Standard in one sum; or

(2) withhold the amount from your future benefits payable under the group policy; or

(3) take any legal action it deems necessary.

Assignment

You may not assign any insurance provided under the group policy. Any such action will be void and of no effect.

The Group Policy

The group policy, your Employer's application, and your application, if any, make up the entire contract between your Employer and The Standard Insurance Company. Any statement in writing made by your Employer or by you will be a representation, not a warranty. No statement made by you will be used to avoid the group policy or in a defense of a claim unless it is in writing, signed by you and a copy of such statement has been furnished to you.

The Standard Insurance Company and your Employer may agree to terminate or change any part of the group policy without your consent. Such termination or change will not affect your benefits for a Disability that then exists.

Also, the group policy will terminate due to non-payment of premiums by your Employer in accordance with the terms of the group policy. And, The Standard Insurance Company may terminate the group policy as of any date set forth below by giving notice in writing that is mailed to your Employer at least 90 days before this date:

(1) The date of the group policy's anniversary; or
(2) Any premium due date, if on a prior premium due date the participation requirements set forth in the group policy have not been met.

Legal Proceedings against The Standard Insurance Company

No action or suit will be brought to recover under the group policy unless it is brought later than 60 days after proof of Disability has been given as required by the group policy. No such action will be brought at all unless it is brought within 3 years from the end of the time within which proof of Disability is required by the group policy.

Service of Process upon The Standard Insurance Company

The Standard Insurance Company will accept service of process in any action or suit against it on the group policy in any court of competent jurisdiction in the United States, Puerto Rico or Canada, if such service is properly made.

The Standard Insurance Company will also accept such process sent to it by registered mail if the plaintiff is a resident of the state, district, territory, or province in which the action or suit is brought. This provision does not waive any of The Standard Insurance Company's rights, including the right to remove an action or a suit to another court.

Incontestability

No statement made by you as to your insurability will be used to contest the validity of your insurance with respect to which the statement was made after your insurance has been in force for two years, nor unless the statement:

(1) is in writing; and
(2) is signed by you; and
(3) a copy is, or has been, given to you.

DEFINITIONS

Where Used In This Certificate, the Following Terms Have the Meaning Set Forth Below Disability or Disabled If You Are an Exempt Employee

...is either:

(1) (a) for the first 60 months of Disability after the end of the Elimination Period, being completely unable due to sickness, bodily injury, or pregnancy to perform the material and substantial duties of your Normal Occupation and not performing any other occupation; and
(b) after that 60 months, being unable due to sickness, bodily injury, or pregnancy to perform the material and substantial duties of any occupation for which you are reasonably qualified by education, training, or experience; or

(2) after at least the number of months shown in PART 1 for the Elimination Period of continuous Disability as defined in (1) above, working but due to continuation of the same Disability, being unable to earn more than 80% of your Increasing Monthly Wage Base.

You must be under the Regular Care of a Physician, other than yourself or a member of your family.

Disability or Disabled If You Are A Non-Exempt Employee

...is either:

(1) (a) for the first 24 months of Disability after the end of the Elimination Period, being completely unable due to sickness, bodily injury, or pregnancy to perform the material and substantial duties of your Normal Occupation and not performing any other occupation; and
(b) after that 24 months, being unable due to sickness, bodily injury, or pregnancy to perform the material and substantial duties of any occupation for which you are reasonably qualified by education, training, or experience; or

(2) after at least the number of months shown in PART 1 for the Elimination Period of continuous Disability as defined in (1) above, working but due to continuation of the same Disability, being unable to earn more than 80% of your Increasing Monthly Wage Base.

You must be under the Regular Care of a Physician, other than yourself or a member of your family.

Normal Occupation

...includes only the essential functions of your occupation that are usually performed for the same type of occupation and that cannot be reasonably omitted or modified considering the normal physical, educational and skill requirements that are needed by the persons who are working in the same occupation.

Regular Care

...is:

(1) regular in-person visits with your Physician as frequently as required under standard medical practice to effectively manage and treat your disabling sickness or injury. Your Physician must be a Physician whose specialty, expertise and experience are appropriate for the care and treatment of your Disability; and

(2) a reasonable program of care and treatment that is, in accordance with accepted medical practice, expected to enhance your ability to work, and which is provided by a Physician

whose specialty, expertise and experience are appropriate for the care and treatment of your Disability. This (2) will not apply if The Standard Insurance Company determines that under accepted medical practice there is no reasonable program of care or treatment for your disabling condition that will enhance your ability to work.

Active Work or Actively at Work

...is performing for wages that are paid regularly by your Employer, the material and substantial duties of your occupation at the usual place of work or at any alternate place of work required by your Employer.

Monthly Wage Base

...is one-twelfth of your basic annual wage payable by your Employer at the start of a term of continuous Disability or just prior to your participation in the Early Phased Retirement Incentive program. The basic annual wage excludes overtime pay, bonuses, and other types of extra compensation. (If your basic annual wage consists of other than twelve monthly payments, your Monthly Wage Base will be one twelfth of the total annual amount of such payments.)

Increasing Monthly Wage Base

...is your Monthly Wage Base increased each year by the Increasing Monthly Wage Base Percentage shown in PART 1 compounded annually. The first increase will take effect as of 12 months after the date TIAA benefits are first payable. Future increases will take effect on the first day of the same month each year thereafter as long as Disability continues.

Monthly Earnings While Disabled

...are one-twelfth of the basic annual wage payable by your Employer or another employer and a monthly portion of other types of compensation (such as self-employment income, grants, or bonuses) for work performed during a term of Disability. If your earnings consist of other than 12 monthly payments, the Monthly Earnings while disabled will be one-twelfth of the total annual amount of such payments. One sum amounts will be divided into monthly amounts to be applied during the term of Disability for which the sum was paid or is estimated by The Standard Insurance Company to have been paid.

Lost Income

...is the Increasing Monthly Wage Base less Monthly Earnings While Disabled.

Physician

...is a physician legally licensed to practice medicine and surgery, or is a person who has a doctoral degree in Psychology (Ph.D. or Psy.D.) and who primarily treats patients.

Mental Illness

...is a mental, nervous, or emotional disease or disorder of any type.

Hospital or Institution

... a facility licensed to provide care and treatment for the condition causing your Disability.

Benefits from Other Sources

...are benefit amounts available or provided to you as set forth below.

One sum amounts will be divided into monthly amounts to be applied during the time for which the sum was applicable or is estimated by The Standard Insurance Company to have been payable.

(A) Social Security or Similar Benefits

...are any benefit amounts that are payable for disability or retirement on your wage record under the Social Security Act of the United States or any similar United States or foreign government program.

(1) Included in these amounts are benefits that are payable to you and to your dependents who are defined as such in the act or program. Any reduced amounts payable for your retirement will be included only if such amounts are elected. Any retirement benefit amounts being paid to you at age 70 or over will not be included if the amounts were being paid prior to the date Disability started.

(2) These amounts will be determined under the provisions of the act or program in effect at the time The Standard Insurance Company benefits are first payable for a term of Disability.

(3) These amounts, except any reduced retirement benefits, will be deemed payable and offset accordingly unless the required application and all available appeals have been filed with and declined by the government program. Before receipt of the government program's final written benefit decision The Standard Insurance Company will estimate the amounts that are payable and will use the estimate to determine the amount of Benefits From Other Sources. If The Standard Insurance Company estimate and amounts awarded differ, The Standard Insurance Company will adjust benefits from other sources accordingly after it receives the final written benefit decision.

(4) If these amounts decrease or stop because you refuse to accept rehabilitation under the act or program The Standard Insurance Company will not adjust benefits from other sources to reflect the change.

(B) Workers' Compensation or Similar Benefits

...are any benefit amounts, including one sum amounts and any form of settlement that are payable under any Workers' Compensation Law or similar law. Benefits from Other Sources will not include amounts paid to you for a continuous disability that starts before a Disability for which benefits are payable under the group policy.

(C) Other Plan Benefits

...are any benefit amounts that are payable for Disability under any plan to which your Employer contributed or for which your Employer deducted funds from your wages.

(D) Other Payments

...are any amounts that are paid under your Employer's sick leave or salary continuation program.

Changes in the Amounts of Benefits from Other Sources ...will not be made by The Standard Insurance Company for:

(1) any cost of living increase that takes effect in such benefits after the date Standard benefits are first payable for a term of Disability; or

(2) any increase in such benefits that is payable for dependents who are acquired after the date The Standard Insurance Company benefits are first payable for a term of Disability.

If any other change occurs in the amounts of benefits from other sources, except as set forth above in (A) (4), the amount of benefits payable by The Standard Insurance Company after the date of the change will be adjusted to reflect the change.

PART 9

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

Statement of Your Rights under the ERISA Law

As a participant in this Disability Plan, you are granted certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). In accordance with ERISA, you are entitled to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all plan documents, including any collective bargaining agreement and copies of all documents filed by the plan with the U.S. Department of Labor and Internal Revenue Service, such as detailed annual reports and plan descriptions.

(2) Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. (The Plan Administrator may make a reasonable charge for the copies.)

(3) Receive a summary of the plan's annual ERISA report to the Internal Revenue Service. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have

the right to have the Plan Administrator review and reconsider the denied applications or requests on eligibility, participation, contributions, or other aspects of the operation of the plan, and to have The Standard Insurance Company review and reconsider denied claims under the Group Insurance contract.

Under ERISA you may take steps to enforce these rights. For example, if you request materials from the Plan Administrator and do not receive them within 30 days you may file suit in federal court, in which case the court can require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless of course the materials were not sent due to reasons beyond the control of the Plan Administrator. If a claim for benefits is denied or ignored, in whole or in part, you may file suit in a state or federal court. If the Plan Administrator's responsibility to remit plan premiums is not discharged according to the terms of this plan or if you are discriminated against for asserting your rights under ERISA, you may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay the court costs and the legal fees. If you are successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees for example, if the court finds the claim is frivolous. Contact your Plan Administrator if you have any questions about this plan. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U.S. Pension and Welfare Benefits Administration, Department of Labor.

EMPLOYER IDENTIFICATION

NUMBER (EIN): 58-0566167
PLAN NUMBER: 503
PLAN EFFECTIVE DATE: July 1, 1988
PLAN ANNIVERSARY: July 1

For information regarding the plan or service of legal process upon the plan, the Plan Administrator should be contacted.

THE PLAN ADMINISTRATOR IS:
Mercer University
1501 Mercer University Drive
Macon, Georgia 31207
(478) 301-2787

FOR INFORMATION CONTACT:
Benefits and Payroll Administration
Mercer University
1501 Mercer University Drive
Macon, Georgia 31207 (478)
301-2787

Employee Assistance Program (EAP)

This service is offered to regular full-time employees who have completed one year of continuous full-time service.

The EAP is a service fully paid by the University that provides short-term counseling to full time faculty, staff, and their families who are facing stressful situations, emotional difficulties, family problems, marital concerns, substance abuse, financial troubles, or other similar challenges.

The counseling provided through EAP is completely confidential; reports are not made to the University to identify who has accessed this service. The utilization of the EAP holds the same level of confidentiality and protection as when seeing any other medical professional. Information will be released only with written permission or as required by law.

The EAP is always available through telephone consultation and online access. The toll-free number is 888-293-6948 or log onto www.eapbda.com. Enter standard as the login ID (in all lower case letters) and eap4u as the password (in all lower case letters).

The program also includes up to three face-to-face assessment and counseling sessions. If an extended period of counseling is needed, the EAP counselor will help make a referral to a physician, psychologist, lawyer, or whatever professional would best meet the needs. If the sources of the problem is emotional, mental or a medical situation, and if the individual is covered under the terms of the Mercer Health Plan, extended counseling will be covered under the Mercer Health Plan.

*This program is offered in connection with group Long Term Disability insurance policies underwritten by Standard Insurance Company.

Flexible Spending Accounts (FSA)

QUALIFYING DEPENDENT/CHILD CARE EXPENSES

Mercer offers the option of depositing funds into a Pre-Tax Account, called a Flexible Spending Account (FSA) for the purpose of paying for services to have your dependent children cared for so that you can work. The services may be provided by a child day care center or at home day care so long as you are paying someone to take care of your children while you are at work. This also applies to the day care of elderly parents if they are dependent upon you for care. Funds withheld from your salary into this account will not be subject to State, Federal or Social Security Taxes and must be used during the fiscal year in which they are withheld or they will be forfeited. FSA is available to Regular Full-Time Employees. ***Participation requires annual re-enrollment each year - it will NOT roll forward from one year to the next.***

Effective Date of Eligibility Effective Immediately

Annual Maximum Deferrals Married:
$5,000 per Year
Single: $2,500 per Year

Your Monthly Cost
The Amount you elect to Defer

Under the plan, you will be reimbursed only for dependent / child care expenses meeting all of the following conditions:

1. The expenses are incurred for services rendered after the date of this election and during the plan year to which it applies.

2. Each individual for whom you incur the expenses is:
   a) a qualifying dependent under age 13 whom you are entitled to claim as a dependent on your federal income tax return
   b) a spouse or other tax dependent who is physically or mentally incapable of caring for himself or herself and lives with you for more than half the year

   If you are divorced, IRS guidelines state that a child is a qualified dependent of the "custodial parent." Only the custodial parent may participate in a dependent care FSA. A divorced, non-custodial parent cannot be reimbursed under a dependent care FSA, even if the divorced parent claims the child as a tax dependent.

3. The expenses are incurred for the care of a dependent described above, or for related household services, and are incurred to enable you to be gainfully employed.

4. If the expenses are incurred for services outside your household, they are incurred for the care of a dependent who is described in 2(a) above, or who regularly spends at least 8 hours per day in your household.

5. If the expenses are incurred for services provided by a dependent care center (i.e., a facility that provided care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.

6. The expenses are not paid or payable to a child of yours who is under age 19 at the end of the year in which the expenses are incurred.

7. The expenses are not paid or payable to an individual for whom you or your spouse is entitled to a personal tax exemption as a dependent.

8. The reimbursement (when aggregated with all other reimbursement received by you under the plan during the same year) may not exceed the least of the following limits.

    a) The maximum amount allowed under the plan;
    b) $5,000 if you are married and filing a joint tax return and $2,500 if separate returns are filed;
    c) Your taxable compensation (after all compensation redirection elections); or (d) If you are married, your spouse's actual or deemed earned income.

For purposes of (d) above, your spouse will be deemed to have income of $200 ($400) if you have two or more dependents described in paragraph 2 above), for each month in which your spouse is (i) physically or mentally incapable of caring for himself or herself, or (ii) a full-time student at an educational institution.

The reimbursement (when aggregated with all other dependent care reimbursements received by you under the plan during the same year) may not exceed the least of the following limits:

(a) The maximum amount allowed under the plan (a) _____

(b) $5,000 if you are married and file a joint tax return, or $2,500 if separate returns are filed (b) _____

(c) Your taxable compensation (after all compensation redirection arrangements) (c) _____

(d) If you are married, your spouse's actual or deemed earned income (d) _____

Dependent/Child Care Assistance Reimbursement Worksheet

This worksheet will help you estimate your annual dependent /childcare assistance costs. This list is not intended to be comprehensive, but may be used as a guide.

Qualifying Expenses		**Estimated Annual Expenses**	
Amounts paid to a dependent care center. (e.g., child day care)	$		
Amounts paid for dependent care services outside your home.			
Amounts paid for dependent care services inside your home.			
TOTAL DEPENDENT / CHILD CARE ASSISTANCE EXPENSES	$		(A)
NUMBER OF PAY PERIODS			(B)
AMOUNTS OF REDIRECTION PER PAY PERIOD PAY PERIOD (A/B)	$		

Child & Dependent Care Expenses must be work related to qualify for the reimbursement under this plan. See IRS Publication 503, for details and examples of qualifying expenses.

Qualifying Medical Care Expenses (Flexible Spending Account)

Mercer offers the option of depositing funds into a Pre-Tax Account, called a Flexible Spending Account (FSA) for the purposes of paying for medical expenses not covered by insurance, such as your Medical and Dental Deductibles, Co-Payments, disallowed charges, etc. Funds withheld from

your salary into this account will not be subject to State, Federal, or Social Security Taxes and must be used during the fiscal year in which they are withheld or they will be forfeited. FSA is available to Regular Full-Time Employees. ***Participation requires annual re-enrollment each year - it will NOT roll forward from one year to the next.***

Effective Date of Eligibility
1st Day of Month after Completion of 3 Months of Service

Annual Maximum Deferrals $2,650 per Year

Your Monthly Cost The Amount you elect to Defer

Under the plan, you will be reimbursed only for those types of medical expenses generally deductible on your federal income tax return (without regard to the 10% adjusted gross income limitation). They include, for example, expenses you have incurred for:

- Medicine, drugs, vaccines, vitamins, and some OTC medicine that your doctor prescribed.
- Medical doctors, dentists, eye doctors, chiropractors, osteopaths, psychiatrists, psychologists, physical therapists, acupuncturists, and psychoanalyst (medical care only).
- Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.
- Hospital care (including meals and lodging), clinic costs, and lab fees.
- Medical treatment at a center for drug addicts or alcoholics.
- Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
- Ambulance service and other travel costs to get medical care. If you use your car, you can claim what you spent for gas and oil to go to and from the place you received the care; or you can claim 12 cents a mile. Add parking and tolls to the amount you claim under either method.

You cannot obtain reimbursement for:

- Premiums incurred by a spouse for accident and health insurance policies.
- The basic cost of Medicare insurance (Medicare A).
- Life insurance or income protection policies.

- The 1.45% hospital insurance benefits tax withheld from your pay as part of the Social Security tax or paid as part of Social Security self-employment tax.

- Nursing care for a healthy baby.

- Illegal operations or drugs.
- Travel your doctor told you to take for rest or change.
- Cosmetic Surgery.
- Dietary supplements.
- Toiletries, cosmetics and sundry items.

Qualifying medical expenses include only those expenses incurred for:

- Yourself.
- Your spouse.
- All dependents you list on your federal tax return.
- Any person that you could have listed as a dependent on your tax return if that person had not received $2,000 or more of gross income or had not filed a joint return.

IRS Publication 502, Medical and Dental Expenses, has a checklist of medical expenses that can be deducted and therefore reimbursed under this plan, and those that cannot. The majority of those items in IRS Publication 502 that can be deducted are approved for Medical Reimbursement Accounts.

Frequently Asked Questions of (Medical) Flexible Spending Accounts (FSA)

Can I rollover unused funds at the end of the plan year?
Yes. The IRS has amended the use-it-or-lose-it rule to allow a limited amount of unused funds to rollover at the end of the plan year. Although the IRS notice calls it “carryover”, we call it “rollover” to match our plan feature.

How much can rollover?
Up to $500 in unused funds can rollover into the following plan year. While the employer can elect to allow less than $500 to be carried over, the same rollover limit must apply to all plan participants.

Does the new rollover rule apply to dependent care FSAs?
No. Your dependent care FSA is independent of this health FSA ruling and remains unaffected.

If rollover is offered, does this change the $2,650 maximum annual election?
No. For example: If the full $500 were to rollover into the following plan year and you elected to contribute the full $2,650 in that year, you would have a total of $3,050 available for reimbursement of eligible healthcare expenses that year.

Does the rollover option affect the run-out period?
No. You will still be able to file claims during the run-out period for expenses incurred during the plan year. This will be useful if you have more than $500 in your FSA account at the end of the year. The length of your run-out period is 45 days.

Do I have to elect a health FSA in the plan year into which funds are rolled over?
No, but you will be limited to only the rollover amount for healthcare expenses in the next plan year. Although you may not be contributing in the rollover year, you remain a participant until your rollover funds are exhausted or your employment is terminated.

How is the rollover amount calculated?
The carryover amount is determined after all expenses have been reimbursed for that plan year (after the end of the plan's run-out period). For example, your plan has a run-out period that ends on August 15 of the following plan year, the amount rolled over for a plan year is equal to the amount from that plan year remaining in the participant's health FSA after August 15 (up to, but no more than $500). Any unused amount in excess of $500 is forfeited.

How long do I have to use my rollover funds?
According to the IRS ruling, "The carryover of up to $500 may be used to pay or reimburse medical expenses under the health FSA incurred during the entire plan year to which it is carried over." The expense must be incurred by the last day of the plan year into which the funds were rolled over. However, if you terminate employment, then you are only eligible for reimbursement for claims with dates of service on or before your termination date.

In what order are funds utilized for new claims?
According to the IRS guidance examples, current year funds should be used prior to any rollover funds being used.

Can I use my benefits debit card to access rollover funds?
Yes. The debit card will access current year funds and then rollover funds.

Are rollover amounts cumulative?
No. The rollover amount from one year to the next is capped at $500. For example, if you have $500 that rolls over from 2013-2014 to 2014-2015, and then you contribute $500 in 2014-2015, but do not file any claims for 2015, the rollover amounts cannot be combined to $1,000 to be carried forward into 2015-2016 —only $500 can be carried forward.

What happens to the rollover if my employment is terminated?
If you leave the company mid-plan year, you are not eligible to receive rollover funds. However, you have a run-out period to submit claims within the dates of service for which you were eligible for reimbursement.

Medical Care Expense Reimbursement Worksheet
This worksheet will help you estimate your annual medical costs that may not be reimbursed by insurance. This list is not intended to be comprehensive, but it contains some of the more common medical expenses.

List all costs that are not reimbursed by insurance incurred by you, your spouse or qualified dependents.

Qualifying Expenses	**Estimated Annual Expenses**
Medical doctor's fees	$
Annual physical examinations	
Dental examinations	
Eye Examinations	
Eyeglasses	
Contact lenses	
Prescription drugs	
X-rays	
Lab fees	
Hospital services	
Chiropractor's fees	
Hearing aids	
Surgery	
Ambulance service	
Nursing home costs	
False Teeth	
Psychiatrist's fees	
Acupuncturist's fees	
Orthodontia	

TOTAL
ESTIMATED ANNUAL EXPENSES $ (A)

NUMBER OF PAY PERIODS
(from date of election to end current plan year) (B)

AMOUNT OF REDIRECTION PER PAY PERIOD (A/B) $

References

[1] 29 CFR 2520.102-3
(Contents of Summary Plan Description)

[2] 29 CFR Chapter XXV 45 CFR Subtitle A
(Coverage for Breast Reconstruction and Related Services After a Mastectomy; Proposed Rule [05/28/1999])

[3] 26 CFR Part 54,
29 CFR Part 2590,
45 CFR Part 144, 146 & 148
(Group Health Plans and Health Insurance Issuers Under Newborns' and Mothers' Health Protection Act; Joint Interim Rule [10/27/1998])

[4] 26 CFR Part 54,
29 CFR Part 2590,
45 CFR 146.111
(Health Insurance Portability for Group Health Plans; Interim Rules and Proposed Rule [04/08/1997])

[5] 29 CFR Part 2590
45 CFR Part 303
(National Medical Support Notice [11/15/1999])

[6] 29 CFR Part 825
(Family Medical Leave Act 1993)