

**SCHEDULE OF BENEFITS
 MEDICAL EXPENSE BENEFITS
 UNIVERSITY OF WEST GEORGIA - INTERCOLLEGIATE SPORTS PLAN
 2013-1195-8
 INJURY ONLY BENEFITS**

**PLEASE NOTE:
 THIS DOCUMENT
 HAS CHANGED. SEE
 THE BACK COVER**

Maximum Benefit	\$40,000 (Per Insured Person) (Per Policy Year)
Deductible Preferred Providers	\$300 (Per Insured Person) (Per Policy Year)
Deductible Out of Network	\$500 (Per Insured Person) (Per Policy Year)
Coinsurance Preferred Providers	80% except as noted below
Coinsurance Out of Network	60% except as noted below

The Preferred Provider for this plan is Multiplan.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Student Health Center Benefits: The Deductible will be waived for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

PREFERRED PROVIDER SERVICES: After the Preferred Provider Deductible has been satisfied, Covered Medical Expenses incurred at a Preferred Provider will be paid at 80% of Preferred Allowance up to an Out-of-Pocket maximum of \$4,500 Per Insured Person. After the Out-of-Pocket maximum has been reached, additional Covered Medical Expenses will be paid at 100% of Preferred Allowance up to the \$40,000 Maximum Benefit.

OUT-OF-NETWORK SERVICES: After the Out-of-Network Deductible has been satisfied, Covered Medical Expenses incurred at an Out-of-Network Provider will be paid at 60% of Usual and Customary Charges up to an Out-of-Pocket maximum of \$7,500 Per Insured Person. After the Out-of-Pocket maximum has been reached, additional Covered Medical Expenses will be paid at 100% of Usual and Customary Charges up to the \$40,000 Maximum Benefit.

This policy provides benefits for Injury sustained by an Insured Person while: 1) actually engaged, as an official representative of the Policyholder, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer of the Policyholder; or 2) actually being transported as a member of a group under the direct supervision of a duly delegated representative of the Policyholder for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

All benefit maximums are combined Preferred Provider and Out-of-Network, unless noted below. The benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

Inpatient	Preferred Provider	Out-of-Network Provider
Room & Board/Hospital	Preferred Allowance	Usual and Customary Charges
Miscellaneous:		
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
Surgery:	Preferred Allowance	Usual and Customary Charges
<i>(Specified Surgery based on data provided by FAIR Health, Inc.)</i>		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Nurse's Services:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing:	Preferred Allowance	Usual and Customary Charges

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Outpatient	Preferred Provider	Out-of-Network Provider
Surgery: <i>(Specified Surgery based on data provided by FAIR Health, Inc.)</i>	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous: <i>(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)</i>	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance	Usual and Customary Charges
	\$20 Copay per visit	
Physiotherapy: <i>(30 visits maximum Per Policy Year)</i>	Preferred Allowance	Usual and Customary Charges
Medical Emergency:	Preferred Allowance	80% of Usual and Customary Charges
X-rays & Laboratory:	Preferred Allowance	Usual and Customary Charges
Tests & Procedures:	Preferred Allowance	Usual and Customary Charges
Injections:	Preferred Allowance	Usual and Customary Charges
Prescription Drugs:	\$15 Deductible per prescription for generic drugs	\$15 Deductible per prescription for generic drugs
	\$30 Deductible per prescription for brand name drugs	\$30 Deductible per prescription for brand name drugs
	up to a 31-day supply per prescription <i>(University Health Center Pharmacy: Copay waived for generic drugs / \$5 Copay per prescription for brand name drugs, \$10 Copay per prescription for non-formulary drugs / up to a 31 day supply per prescription if prescription is filled at the University Health Center Pharmacy.)</i>	up to a 31-day supply per prescription
Other	Preferred Provider	Out-of-Network Provider
Ambulance:	70% of Preferred Allowance <i>(If ambulance referral is initiated by Student Health Center, Deductible is waived.)</i>	70% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
Consultant:	Preferred Allowance	Usual and Customary Charges
Dental: <i>(Injury to Sound, Natural Teeth only.)</i>	Preferred Allowance	80% of Usual and Customary Charges

**SUPPLEMENTAL MEDICAL
 Maximum Benefit No Benefits**

**CATASTROPHIC MEDICAL
 Maximum Benefit No Benefits**

*SHC (Student Health Center) Referral Required: Yes () No (X) Conversion Permitted: Yes () No (X)

*Pre Admission Notification: Yes () No (X)

() 52 Week Benefit Period or (X) Extension of Benefits

Other Insurance: (X) *Coordination of Benefits () Primary Insurance

*If benefit is designated, see endorsement attached.

PART VII
EXCLUSIONS AND LIMITATIONS

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to:

1. Biofeedback;
2. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;
3. Dental treatment, except for accidental Injury to Sound, Natural Teeth;
4. Elective Surgery or Elective Treatment; Elective abortion;
5. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems;
6. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
7. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
8. Hirsutism; alopecia;
9. Preventive medicines or vaccines, except where required for treatment of a covered Injury;
10. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
11. Investigational services;
12. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
13. Prescription Drugs, services or supplies as follows:
 - a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use;
 - b) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
 - c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - d) Anabolic steroids used for body building;
 - e) Growth hormones; or
 - f) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

EXCLUSIONS AND LIMITATIONS (Continued)

14. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
15. Deviated nasal septum, including submucous resection and/or other surgical correction thereof;
16. Sickness or disease in any form; over-exertion, fainting; or hernia, regardless of how caused;
17. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
18. Sleep disorders;
19. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and
20. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).