SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS
KENNESAW STATE UNIVERSITY - INTERCOLLEGIATE SPORTS PLAN
2013-599-8
INJURY ONLY BENEFITS

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 UnitedHealthcare Options PPO.

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. Note: Balance billing will not apply toward the annual Deductible or toward the maximum annual out-of-pocket.

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.

UnitedHealthcare Pharmaceutical Solutions is the vendor the company contracts with to provide a network of pharmacies.

Inpatient	**Preferred Provider**	**Out-of-Network Provider**
Room & Board/Hospital Miscellaneous:	Preferred Allowance	Usual and Customary Charges
Intensive Care:	Preferred Allowance	Usual and Customary Charges
Physiotherapy:	Preferred Allowance	Usual and Customary Charges
Surgery:	Preferred Allowance	Usual and Customary Charges
(Specified Surgery based on data provided by FAIR Health, Inc.)		
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

Outpatient	**Preferred Provider**	**Out-of-Network Provider**
Surgery:	Preferred Allowance	Usual and Customary Charges
(Specified Surgery based on data provided by FAIR Health, Inc.)		
Day Surgery Miscellaneous:	Preferred Allowance	Usual and Customary Charges
(Day Surgery Miscellaneous charges are based on the Outpatient Surgical Facility Charge Index.)		
Assistant Surgeon:	Preferred Allowance	Usual and Customary Charges

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Outpatient	**Preferred Provider**	**Out-of-Network Provider**
Anesthetist:	Preferred Allowance	Usual and Customary Charges
Physician's Visits:	100% of Preferred Allowance $20 Copay per visit	Usual and Customary Charges
Physiotherapy: *(30 visits maximum Per Policy Year)*	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 $30 Deductible per prescription for brand name up to a 31-day supply per prescription *(University Health Center Pharmacy: Copay waived for generic drugs / $5 Copay per prescription for brand name, $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.)*	$15 Deductible per prescription for generic drugs $30 Deductible per prescription for brand name up to a 31-day supply per prescription

Other	**Preferred Provider**	**Out-of-Network Provider**
Ambulance:	70% of Preferred Allowance *(If ambulance referral is initiated by Student Health Center, Deductible is waived. Subject to balance billing for non-participating/non-covered providers of ambulance services.)*	70% of Usual and Customary Charges
Durable Medical Equipment:	Preferred Allowance	Usual and Customary Charges
Consultant:	Preferred Allowance	Usual and Customary Charges
Dental: *(Injury to Sound, Natural Teeth only.)*	Preferred Allowance	Usual and Customary Charges
Repatriation:	Benefits provided by FrontierMEDEX	Benefits provided by FrontierMEDEX
Medical Evacuation:	Benefits provided by FrontierMEDEX	Benefits provided by FrontierMEDEX
AD&D:	No Benefits	No Benefits

SUPPLEMENTAL MEDICAL

Maximum Benefit No Benefits

CATASTROPHIC MEDICAL

Maximum Benefit No Benefits

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

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

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

Other Insurance: (X) *Coordination of Benefits ( ) Excess Motor Vehicle ( ) 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 or for newborn or adopted children; removal of warts, non-malignant moles and lesions;

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; except when due to a disease process;

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 or Sickness 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, except as specifically provided in the Benefits for Diabetes;
    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, except as specifically provided in the Benefits for Drug Treatment for Children’s Cancer;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;

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; nasal and sinus surgery;

16. 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;

17. Sleep disorders;

18. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; and

19. 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).