

Rockford University
2018-2019 Student Health Plan

Group No: ST0896SH
 Policy No: CCIC1819ILSHIP01

Dear Students:

We are pleased to provide you with this summary of the Student Health Plan for Rockford University. This plan is fully compliant with the Affordable Care Act.

Who is Eligible to Enroll?

All full-time students taking 12 or more credit hours, international students and students participating in athletics are eligible to enroll in this insurance plan. Part-time and graduate students taking 3 or more credit hours are also eligible to enroll.

How Do I Enroll?

Full-time students, international students and student athletics are automatically enrolled in the plan. Part-time and graduate students can enroll in the plan on a voluntary basis. Students who purchase coverage authorize the University to add the premium to the student's account by completing the online enrollment.

How do I Waive Coverage?

Students who are covered by another comparable plan, may waive this coverage by completing the online waiver. Students who do not complete a waiver form by the waiver deadline date will automatically be enrolled in the plan and premium added to student's account.

Waiver Period Deadline Date	
Annual	September 7, 2018
Cost and Periods of Coverage	
	Annual 08-09-2018 to 08-08-2019
Student	\$2,200
The above rates include administrative fees.	
Where Can I Obtain more Information about the Plan?	
Waive off or Enroll in the Student Health Plan	College Website www.rockford.edu/community/campus/lang/formsa/ndinsurance/
Insurance Benefits Claim Processing ID Cards/ Requests	Consolidated Health Plans (CHP) www.chpstudenthealth.com
Preferred PPO Provider Listings	Consolidated Health Plans (CHP) www.chpstudenthealth.com OR Cigna www.cigna.com

Underwritten By:
 Commercial Casualty Insurance Company

Plan Administrator:
 Consolidated Health Plans, Inc.
 2077 Roosevelt Ave.
 Springfield, MA 01104
 chpstudenthealth.com
 (877) 657-5030

Servicing Agent:
 Williams-Manny, Inc.
 Laura Penwarden
 Phone: 815-387-4870
 Fax: 815-398-6772
 laura.penwarden@wmanny.com

HEALTH INSURANCE BENEFIT SUMMARY*		
BENEFIT	NETWORK	NON-NETWORK
Benefit Maximum	Unlimited	
Annual Deductible	\$150	\$300
Out-of-Pocket Maximum	\$6,600	No Maximum
Coinsurance	80% of PA	60% of U&R
Student Health Center	100% of Actual Charge for covered Medical Expenses (Deductible waived)	
Preventive Care	100% of PA (no cost sharing)	60% of U&R
Hospital Room & Board (Inpatient)**	80% of PA	60% of U&R
Surgery (Inpatient or Outpatient)	80% of PA	60% of U&R
In Office Physician Visit	80% of PA after \$25 copay per visit	60% of U&R after \$25 copay per visit
Consultant or Specialist Visit	80% of PA after \$25 copay per visit	60% of PA after \$25 copay per visit
Emergency Services Expense (Copay waived if admitted)	80% of PA after \$100 copay	80% of U&R after \$100 copay
Urgent Care Centers/Facilities	80% of PA after \$75 copay	60% of U&R after \$75 copay
Diagnostic X-ray & Laboratory	80% of PA	60% of U&R
Outpatient Prescription Drugs (benefits provided on reimbursement basis)	80% of Actual Charges after \$10 copay per Generic Drug \$25 copay per Preferred Brand Drug \$35 copay per non-Preferred Brand Drug \$35 copay per Specialty Drug	
PA= Preferred Allowance		U&R=Usual and Reasonable
*This is only a brief description of the coverage(s) available under Certificate form IL SHIP CERT (2018). The Certificate will contain the reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.		
**All inpatient confinements require pre-certification. The phone number can be found on the back of the Insured's ID card. The call should be made prior to Hospital Confinement. In the case of an emergency, the call should take place as soon as reasonably possible		

The following Value-Added Services are not part of the Policy and are not underwritten by Commercial Casualty Insurance Company. The services are provided by independent vendors and are included if the student participates in the student health plan.

- Vision discount program through Davis Vision

- Medical travel assistance through Scholastic Emergency Services
- 24-hour nurse line through Ask Mayo Clinic
- 24-hour behavioral health hotline application through CareConnect

Exclusions

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act, or any state-imposed requirements will be administered to comply with the requirements of federal or state guideline, whichever is more favorable. to You.

The Certificate does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Certificate and as shown in the Schedule of Benefits.

1. **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the Student Health Center or by the person's attending physician or dentist.
3. Medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits or as part of the Student Health Center benefits provided by this plan.
4. Professional services rendered by an Immediate Family Member or anyone who lives with You.
5. Weak, strained or flat feet corns, calluses ingrown toenails except for Treatment because of Injury, infection or disease.
6. Prescription contraceptive diaphragms are covered but limited to one (1) per Policy Year;
7. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
9. Any expenses in excess of Usual and Reasonable charges except as provided in the Certificate.
10. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world
11. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
13. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
14. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
15. Expenses payable under any prior Certificate which was in force for the person making the claim.
16. Injury sustained as the result of You operating a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
17. Expenses incurred after: a. The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision and b. The end of the Policy Year specified in the Benefit Schedule.
18. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Certificate.
19. Charges incurred for acupuncture, heat Treatment, diathermy, or massage, in any form, except to the extent provided in the Schedule of Benefits.
20. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
21. Expenses for radial keratotomy, eye glasses or contact lenses except as required for repair caused by a Covered Injury, Office visit exam for the fitting or prescription contact lenses, eye glasses or duplicate spare eyeglasses or lenses or frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes or unless otherwise covered under the Pediatric Vision Care Benefit.
22. Charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids except as specifically provided in the Certificate.
23. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical Treatment within 24 hours of the Accident or results from Reconstructive Surgery.
 - For the purposes of this provision, **Reconstructive Surgery** means surgery performed to corrector repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
 - For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance or alter their personal concept of body image.
24. Treatment to the teeth, including orthodontic braces and orthodontic appliances, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
25. You are:
 - committing or attempting to commit a felony,
 - being engaged in an illegal occupation, or
 - participation in a riot.
26. Elective abortions.
27. Braces and appliances, except as specifically provided in the Schedule of Benefits.

28. Congenital defects, except as provided for newborn or adopted children added after the effective date of coverage.
29. Custodial Care service and supplies.
30. Charges for hot or cold packs.
31. Expenses that are not recommended and approved by a Physician.
32. Sexual reassignment surgery, except as provided when Medically Necessary or when Treatment is covered under the Certificate. This exclusion does not include related mental health counseling or hormone therapy.
33. Routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
34. Cosmetic procedures related to Gender Dysphoria including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
35. Sleep Disorders screening including testing.
36. Under the Prescription Drug Benefit shown in the Schedule of Benefits, any drug or medicine:
 - Which do not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided in the Prescription Drug Benefit section of this plan;
 - Drugs with over-the-counter equivalents;
 - Allergy sera and extracts administered via injection;
 - for the purpose of weight control;
 - Vitamins, minerals, food supplements;
 - Dietary supplements
 - Cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or Treatment of acne except as specifically provided in the Certificate;
 - Blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) prescription order per Policy Year;
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
 - Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
 - Purchased after coverage under the Policy terminates;
 - Consumed or administered at the place where it is dispensed;
 - If the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason.
 - Bulk chemicals;
 - Non-insulin syringes surgical supplies durable medical equipment/medical devices with the exception of diabetic blood monitors and kits;
 - Stimulants;
 - Repackaged products;
 - Blood components;
 - immunology products
37. Non-chemical addictions.
38. Non-physical, occupational, speech therapies (art, dance, etc.).
39. Modifications made to dwellings.
40. General fitness, exercise programs.
41. Hypnosis.
42. Rolfing.
43. Biofeedback, except for the treatment of a Mental Health Disorder.
44. Hyperhidrosis.