

Rockford University
2019-2020 Student Health Plan

Group No: ST0896SH
Policy No: CCIC1920ILSHIP63

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 hour are also eligible to enroll.

How Do I Enroll?

Full-time students, international students, residential students and students participating in intercollegiate 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 form on the University's website.

How do I Waive Coverage?

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

Waiver Period Deadline Date

Annual	September 6, 2019
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Cost and Periods of Coverage

	Annual 8/9/2019 to 8/8/2020
Student	\$2,400
The above rate includes an administrative fee	

Where Can I Obtain more Information about the Plan?

Waive off or Enroll in the Student Health Plan	University Website www.rockford.edu/community/campus/lang/formsandinsurance
Insurance Benefits Claim Processing ID Cards	Wellfleet Group, LLC www.wellfleetstudent.com
Find Network Provider	Wellfleet Student or Cigna www.wellfleetstudent.com

The plan described in this Summary is awaiting approval by the Illinois Department of Insurance. If the plan is changed during the approval process, a revised Summary will be provided. This is not an insurance policy and your receipt of this document does not constitute the issuance or delivery of a policy of insurance.

Underwritten By:
Commercial Casualty Insurance Company

Plan Administrator:
Wellfleet Group, LLC
PO Box 15369
Springfield, MA 01115-5369
wellfleetstudent.com
(877) 657-5030

Servicing Agent:
Gallagher
Adriana Durán Krauss
Phone: (815) 227-8956
Fax: (815) 231-7054

HEALTH INSURANCE BENEFIT SUMMARY FOR COVERED MEDICAL EXPENSES*

Unless otherwise specified below the medical plan deductible will always apply

BENEFIT	IN-NETWORK	OUT OF NETWORK
Policy Year Deductible	\$150 Individual	\$300 Individual
Out-of-Pocket Maximum	\$6,600 Individual	No Maximum
Coinsurance	80% of NC**	60% of U&C**
Student Health Center	100% of Actual Charge for covered medical expenses, deductible waived	
Preventive Care	100% of NC Deductible Waived	60% of U&C
Hospital Room & Board (Inpatient)	80% of NC	60% of U&C
Surgery (Inpatient or Outpatient)	80% of NC	60% of U&C
Physician Office Visit OR Consultant/Specialist	\$25 copay per visit, then plan pays 80% of NC	\$25 copay per visit, then plan pays 60% of U&C
Emergency Services Expense (Copay waived if admitted)	\$100 copay per visit, then plan pays 80% of NC	Paid the same as In-Network, provider subject to U&C
Urgent Care Center/Facilities	\$75 copay per visit, then plan pays 80% of NC	\$75 copay per visit, then plan pays 60% of U&C
Imaging Services & Laboratory Services (Outpatient)	80% of NC	60% of U&C
Sports Accident Expense for Intercollegiate, Club Sports	80% of NC	60% of U&C
Outpatient Prescription Drugs (Copay per drug; per 30-day supply) Out-of-Network Provider benefits provided on a reimbursement basis.	Generic: \$10 copay per drug Preferred: \$25 copay per drug Non-Preferred 3: \$35 copay per drug Specialty: \$35 copay per drug Then the plan pays 80% for Actual Charge; after the Deductible	
**NC=Negotiated Charge for Covered Medical Expenses **U&C=Usual and Customary for Covered Medical Expenses		
*This is only a brief description of the coverage(s) available under Certificate form IL SHIP CERT (2019). 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.		
Pre-certification is required for inpatient hospital, surgery and selected outpatient services. Pre-Certification is not required for an Emergency Medical Condition or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care		

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 AHH

EXCLUSIONS AND LIMITATIONS

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 the 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 You 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 Your attending Physician or dentist.
3. Medical services rendered by a provider employed for or contracted with the Policyholder, 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.
6. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary because of Injury, infection or disease.
7. Infertility treatment (male or female)-this includes but is not limited to:
 - Procreative counseling (except for the evaluation to determine if and why a couple is infertile);
 - Premarital examinations;
 - Genetic counseling and genetic testing;
 - Impotence, organic or otherwise;
 - Injectable infertility medication, including but not limited to menotropins, hCG and GnRH agonists;
 - Costs for an ovum donor or donor sperm;
 - Sperm storage costs;
 - Cryopreservation and storage of embryos;
 - Ovulation induction and monitoring;
 - Hysteroscopy;
 - Laparoscopy;
 - Laparotomy;
 - Ovulation predictor kits;
 - Reversal of tubal ligations;
 - Reversal of vasectomies;
 - Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
 - Cloning; or
 - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.
8. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
9. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services covered by Student Health Fees.
10. Any expenses in excess of Usual and Customary Charges except as provided in the Certificate.
11. 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.
12. 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.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. 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.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
 16. Expenses paid under any prior policy which was in force for the person making the claim.
 17. Expenses incurred after:
 - The date insurance terminates as to an Insured Person, except as specified in the extension of benefits provision; and
 - The end of the Policy Year specified in the Policy.
 18. Elective Surgery or Elective Treatment unless such coverage is otherwise specifically covered under the Certificate.
 19. Charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
 20. Weight management. Weight reduction. Nutrition programs. This does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Services benefit, or otherwise specifically covered under the Certificate.
 21. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat.
 22. Charges for hair growth or removal unless otherwise specifically covered under the Certificate.
 23. Expenses for radial keratotomy.
 24. Adult Vision unless specifically provided in the Certificate.
 25. Charges for office visit exam for the fitting of prescription contact lenses, duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.
 26. Charges for hearing exams, hearing screening, and the fitting or repair or replacement of hearing aids or cochlear implants.
 27. Surgery or related services for cosmetic purposes to improve appearance, except to restore bodily function or correct deformity resulting from disease, or trauma.
 28. Treatment to the teeth, including orthodontic braces and orthodontic appliances, unless otherwise covered under the Pediatric Dental Care Benefit.
 29. You are:
 - committing or attempting to commit a felony,
 - engaged in an illegal occupation, or
 - participating in a riot.
 30. Elective abortions.
 31. Custodial Care service and supplies.
 32. Charges for hot or cold packs for personal use.
 33. Braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.
 34. Services of private duty Nurse except as provided in the Certificate.
 35. Expenses that are not recommended and approved by a Physician.
 36. 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.
 37. Cosmetic procedures related to Gender Reassignment 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.
 38. Sleep Disorders, except for the diagnosis and treatment of obstructive sleep apnea.
 39. Treatment of Acne unless Medically Necessary.
 40. Experimental or Investigational drugs, devices, treatments or procedures unless otherwise covered under Covered Cancer Clinical Trials or covered under clinical trials (routine patient costs). See the Other Benefits section for more information.
 41. Under the Prescription Drug Benefit shown in the Schedule of Benefits:
 - any drug or medicine which does 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 under Preventive Services or in the Prescription Drug Benefit section of this Certificate. Insulin and OTC preventive medications required under ACA are exempt from this exclusion;
 - drugs with over-the-counter equivalents except as specifically provided under Preventive Services;
 - allergy sera and extracts administered via injection;

- any drug or medicine for the purpose of weight control;
 - vitamins, and minerals, except as specifically provided under Preventive Services;
 - food supplements, dietary supplements; except as specifically provided in the Certificate;
 - cosmetic drugs or medicines, including but not limited to, products that improve the appearance of wrinkles or other skin blemishes;
 - refills in excess of the number specified or dispensed after 1 year of date of the prescription;
 - drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
 - any drug or medicine purchased after coverage under the Certificate terminates;
 - any drug or medicine 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, except as specifically provided in the Prescription Drug Benefit section of the Certificate;
 - repackaged products;
 - blood components except factors;
 - immunology products.
42. Non-chemical addictions.
 43. Non-physical, occupational, speech therapies (art, dance, etc.).
 44. Modifications made to dwellings.
 45. General fitness, exercise programs.
 46. Hypnosis.
 47. Rolfing.
 48. Biofeedback.