

**Student Health  
Insurance Plan**

**Plan Year  
18/19**

*Designed Exclusively for the Students of:*  
**Northeast Ohio Medical University**  
Rootstown, OH  
("the Policyholder")

**2018 - 2019**

*Underwritten by:*  
Commercial Casualty Insurance Company  
Fort Wayne, IN  
("the Company")

Policy Number: CCIC1819OHSHP25

Group Number: ST1275SH

Effective:  
2<sup>nd</sup> – 4<sup>th</sup> Year Students: 7/1/18 – 6/30/19  
New Students: 8/27/18 – 6/30/19



*Administered by:*  
Consolidated Health Plans  
2077 Roosevelt Ave | Springfield, MA

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## Where to Find Help

For Questions About:	Please Contact:
<b>Enrollment</b> <b>Insurance Benefits</b> <b>Claims Processing</b> <b>ID Cards</b>	<b>Consolidated Health Plans (CHP)</b> <a href="http://www.chpstudenthealth.com">www.chpstudenthealth.com</a>
<b>Waiver</b>	<a href="http://www.haylor.com">www.haylor.com</a>
<b>Preferred PPO Provider Listings</b>	<b>Consolidated Health Plans</b> <a href="http://www.chpstudenthealth.com">www.chpstudenthealth.com</a> or <b>Cigna</b> <a href="http://www.cigna.com">www.cigna.com</a>
<b>Prescription Drug Providers</b>	<b>Cigna Pharmacy</b> <a href="http://www.cigna.com">www.cigna.com</a>

## Am I Eligible?

You are eligible for Coverage under the Certificate. Coverage includes Dependent coverage.

Students must attend classes for the first 31 days beginning with the first day for which coverage is effective. Any student withdrawing from the College during the first 31 days after the Effective Date of coverage shall not be covered under the insurance plan. A full refund of premium will be made, minus the cost of any claim benefits paid by the Certificate. Students who graduate or withdraw from the College after the first 31 days, whether involuntarily or voluntarily, will remain covered under the Certificate for the term purchased and no refund will be allowed.

Students withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school. Students will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have a J-1, F-1 or M-1 Visa and dependents have a J-2, F-2 or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid.

Eligibility requirements must be met each time Premium is paid to renew Coverage.

### Who is Eligible

All registered College of Medicine and College of Pharmacy students taking credits are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan unless proof of comparable coverage is provided by completing the waiver.

All registered Graduate students taking credits are eligible to enroll in this Student Health Insurance Plan on a voluntary basis. Please visit [www.chpstudenthealth.com](http://www.chpstudenthealth.com) for enrollment information.

### Who is not Eligible

The following students are not eligible to enroll in the insurance plan:

- students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses;
- students taking home study, correspondence courses do not fulfill the eligibility requirements that the student actively attend classes.

## Coverage for Dependents

Eligible students may also insure, on a Voluntary Participation Basis, their eligible Dependents. Individuals who enroll their dependents must enroll them within 31 days of the Insured Student's enrollment in the plan with the exception of adopted children or newborn children (see the Certificate provision entitled **Dependent Child Coverage**). They will be enrolled for the same term of coverage for which the Insured Student enrolls. Dependents of an **Eligible International Student** must possess a valid passport and a proper Visa (either an F-2, J-2 or M-2 visa).

## How Do I Waive/Enroll?

### To Enroll:

All registered College of Medicine and College of Pharmacy students taking credits are automatically enrolled in the Plan unless proof of comparable coverage is provided by completing a waiver. To waive, see directions below.

All registered Graduate students taking credits can enroll by going to:

<https://link.zixcentral.com/u/aae7ffc4/RIW4BWIY6BGoBf0lh3soMg?u=http%3A%2F%2Fwww.haylor.com%2Fcollege%2Fnortheast-ohio-medical-university>

### To Waive:

To document proof of comparable coverage, students need to complete the online Waiver Form and submit it prior to the start of the school year. The deadline to waive for the annual plan is July 30, 2018. To submit the online Waiver Form:

1. Go to [www.haylor.com](http://www.haylor.com), select your school from the drop down box;
2. Click on the Waiver option link; and
3. Complete all of the required information as directed.

- ANNUAL WAIVER DEADLINE – **July 30, 2018**

## Special Enrollment - Qualifying Life Event

You, and Your Spouse or Child can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other health plan due to:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated for You or Your Dependent's Coverage; or
7. A Child no longer qualifies for coverage as a Child under the other health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

In addition, You, and Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following event:

1. You or Your Spouse or Child lose eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Child become eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder’s term of coverage begins; or (4) the date You become a member of an eligible class of persons.

## Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

### Enrollment Dates for New Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	8/27/18	6/30/19	7/30/18
Fall	8/27/18	12/31/18	7/30/18
Spring	1/1/19	6/30/19	N/A

### Rates for New Students

Dependent rates are in addition to the student rate.

	Annual	Fall	Spring
Student*	\$2,158	\$890	\$1,268
Spouse*	\$2,158	\$890	\$1,268
Each Child*	\$2,158	\$890	\$1,268
3 or more Children*	\$6,474	\$2,670	\$3,804

*\*The above rates include an administrative service fee*

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

### Enrollment Dates for 2<sup>nd</sup> - 4<sup>th</sup> Year Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	7/1/18	6/30/19	7/30/18
Fall	7/1/18	12/31/18	7/30/18
Spring	1/1/19	6/30/19	N/A

**Rates for 2<sup>nd</sup> - 4<sup>th</sup> Year Students**

Dependent rates are in addition to the student rate.

	Annual	Fall	Spring
<b>Student*</b>	\$2,557	\$1,289	\$1,268
<b>Spouse*</b>	\$2,557	\$1,289	\$1,268
<b>Each Child*</b>	\$2,557	\$1,289	\$1,268
<b>3 or more Children*</b>	\$7,671	\$3,867	\$3,804

*\*The above rates include an administrative service fee*

**Effective Dates:** Insurance under the Certificate will become effective on the later of:

1. The Policy Effective Date;
2. The beginning date of the term for which premium has been paid;
3. The day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed;
5. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

Dependent’s coverage, under the Voluntary Participation Basis, becomes effective on the later of:

1. The day after the date of postmark when the Enrollment Form is mailed; or
2. The beginning date of the term for which premium has been paid; or
3. The day after the date the required individual Enrollment Form and premium payment are received by Us or Our authorized agent. This applies only when premium payment is made within 31 days of Your enrollment in the School’s insurance plan; or
4. The Policy Effective Date.

The enrollment Period will run from the start of the quarter or semester for which coverage is desired.

## Termination of Benefits

**Termination Dates:** Your insurance will terminate on the earliest of:

1. The date the Certificate terminates for all Insured Persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date You cease to be eligible for the insurance; or
4. The date You enter military service or
5. For International Students, the date they cease to meet Visa requirements; or
6. For International Students, the date they depart the Country of Assignment for his/her Home Country (except for scheduled school breaks); or
7. On any premium due date the Policyholder fails to pay the required premium for You except as the result of an inadvertent error and subject to any Grace Period provision.

## Refund of Premium

Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:

1. For any student who does not attend school during the first thirty-one (31) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium will be made minus any claims paid.

2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made for such person upon written request received by Us within 90 days of withdrawal from school.
3. For International Students and/or their covered Dependents. We will refund a pro rata portion of the premium actually paid (less any claims paid) for any individual who:
  - o Withdraws from School during their first semester; and
  - o Returns to their Home Country on a permanent basis.
 A written request must be sent to us within 60 days of such departure.

No other refunds will be allowed.

## Definitions

These are key words used in the Certificate. Reference should be made to these words as the Certificate is read.

**Accident** means a sudden, unforeseeable external event which directly and from no other cause results in an Injury to the Insured Person.

**Ambulance Service** means transportation by a licensed Ambulance (including ground, water, fixed wing and rotary wing air transportation), in a medical emergency.

**Ambulatory Surgical Center** A facility, with an organized staff of Physicians, that:

1. Is licensed as such, where required;
2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
4. Does not provide Inpatient accommodations; and
5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

**Anesthetist** means a Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

**Assistant Surgeon** means a Physician who assists the Surgeon who actually performs a surgical procedure.

**Brand Name Prescription Drugs** means a Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.

**Certificate:** The Certificate issued by Us, including the Schedule of Benefits and any attached riders.

**Coinsurance** means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

**Complications of Pregnancy** means conditions that require Hospital Confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

**Confinement/Confined** means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a seventy-two (72) hour period, will be considered

a continuation of the Confinement. Confinement does not include observation, which is a review or assessment of eighteen (18) hours or less, of an Insured Person's condition that does not result in admission to a Hospital or health care facility.

**Copayment** means a specified dollar amount You must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

**Country of Assignment** means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

**Covered Injury or Injury** means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. All Injuries sustained in any one (1) Accident, all related conditions and recurrent symptoms of these Injuries are considered a single Injury.

**Covered Medical Expense** means those Medically Necessary charges for any Treatment, service or supplies that are:

1. Not in excess of the Usual and Reasonable charges therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Preferred Allowance; and
4. Incurred while Your Certificate is in force.

**Covered Sickness** means an illness, disease or condition including pregnancy and Complications of Pregnancy that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

**Custodial Care** means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

**Deductible** means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

**Dependent** means:

1. An Insured Student's lawful spouse or lawful Domestic Partner;
2. An Insured Student's dependent biological or adopted child or stepchild or if the Insured Student is required by a court or administrative order to provide coverage of a child under age 26; and
3. An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is:
  - a. primarily dependent upon the Insured Student for support and maintenance; and
  - b. incapable of self-sustaining employment by reason of intellectual disability or physical handicap. Proof of the child's incapacity or dependency must be furnished to Us within 31 days for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan. Upon request but not more frequently than annually after the two (2) year period following the child's attainment of the limiting age, We may require proof of the continuance of such incapacity and dependency.

**Durable Medical Equipment** means a device which:

1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively You;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
5. Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.



Durable Medical Equipment does not include:

1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. Equipment that may increase the value of the Insured Person's residence.

**Effective Date** means the date coverage becomes effective.

**Elective Surgery or Elective Treatment** means those health care services or supplies not medically necessary for the care and treatment of a Covered Injury or Covered Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

**Eligible Cancer Clinical Trial** means a cancer clinical trial that meets all of the following criteria:

1. The purpose of the trial is to test whether the intervention may improve the participant's health or the treatment is given with the intention of improving the participant's health, and is not designed to test toxicity or disease pathophysiology
2. The trial does one of the following:
  - a. Tests how to administer and the responses to health care services, items, or drugs for cancer treatment
  - b. Compares the effectiveness of a health care service, item, or drug for cancer treatment
  - c. Studies new uses of health care services, items, or drugs for cancer treatment
3. The trial is approved by one of the following:
  - a. The National Institutes of Health
  - b. The Food and Drug Administration
  - c. The Department of Defense
  - d. The Department of Veterans Affairs
  - e. The Centers for Disease Control and Prevention
  - f. The Agency for Health Care Research and Quality
  - g. The Centers for Medicare & Medicaid Services
  - h. Cooperative group or center of any of the entities described above
  - i. The Department of Energy

**Eligible Student** means a student who meets all eligibility requirements of the School named as the Policyholder or Dependent of the Insured Student.

**Emergency Medical Condition** means a Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

**Emergency Services** means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital, including any trauma and burn center of the hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

**Essential Health Benefits** mean benefits that are defined in Section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of covered services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;

5. Mental health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitative and Habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

**Experimental/Investigative** means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see the Medically Necessary/Medical Necessity provision.

**Formulary** means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary indicates the type of drug and tier status.

**Generic Prescription Drugs** means any Prescription drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

**Habilitation/Habilitative Services** means health care services and devices that help the Insured Person keep, learn, or improve skills and functions for daily living. Examples include therapy for a child who is not walking or talking at the expected age. Habilitative Services may include such services as Physical Therapy, Cardiac Rehabilitation, occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Home Health Care Agency** means an agency that:

1. is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. is engaged primarily in providing skilled nursing facility services and other therapeutic services in the Insured Person's Home under the supervision of a Physician or a Nurse; and
3. maintains clinical records on all patients.

**Home Health Care** means the continued care and treatment of an Insured Person if:

1. institutionalization of the Insured Person would have been required if Home Health Care was not provided; and
2. the Insured Person's physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
  - a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
  - b. a public or private health service or agency that is licensed as a Home Health Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

**Hospice** means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

**Hospital** means a facility which provides diagnosis, Treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified

and licensed as such under the laws where located. It shall also include Rehabilitative facilities if such is specifically required for Treatment of physical disability.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

**Immediate Family Member** means You and Your spouse or the parent, child, brother or sister of Yours or Your spouses.

**Insured Person** means an Insured Student or Dependent of an Insured Student while insured under the Certificate.

**Insured Student** means a student of the Policyholder who is eligible and insured for coverage under the Certificate.

**International Student** means an international student:

1. With a current passport and a student Visa;
2. Who is temporarily residing outside of his or her Home Country; and
3. Is actively engaged as a student or in educational research activities through the Policyholder.

In so far as the Certificate is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

**Loss** means medical expense caused by an Injury or Sickness which is covered by the Certificate.

**Maintenance Prescription Drug** means a Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drug. Refer to the Formulary for tier status.

**Medically Necessary or Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide to an Insured Person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured Person's illness, injury or disease; and
3. not primarily for the convenience of the Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of that Insured Person's illness, injury or disease.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

**Mental Health Disorder** A display of mental or nervous symptom that are not a result of any physical or biological causes(s) or disorder(s). Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Non-Preferred Drug** means a drug that makes up the formulary drug list and may have a higher out-of-pocket cost.

**Non-Preferred Providers** have not agreed to any pre-arranged fee schedules.

**Nurse** means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

**Organ Transplant** means the moving of an organ from one body to another or from a donor site to another location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

**Out-of-Pocket Maximum** means the most each Insured Person will pay during a Policy Year before coverage begins to pay 100% of the allowed amount. This limit will never include premium, balance-billed charges or health care the Policy does not cover. Your Non-Preferred Provider payments or other non-covered expenses and Elective Treatment do not count toward this limit.

**Physical Therapy** means any form of the following:

1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

**Physician** means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under the Certificate, and who is not:

1. The Insured Person;
2. An Immediate Family Member; or
3. A person employed or retained by the Insured Person.

**Policy Year:** Is the Policy Term shown on the first page of the Certificate. Coverage renewal is guaranteed as long as the Policy remains in force and You continue to meet the eligibility requirements of the Certificate and premiums are paid.

**Policy:** means the Policy issued between Us and the Policyholder.

**Policyholder:** The institution of higher education that has entered into an agreement with Us.

**Preadmission Testing** means tests done in conjunction with and within 5 days of a scheduled surgery where an operating room has been reserved before the tests are done.

**Preferred Allowance** means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

**Preferred Drug** means a Formulary drug that is within a select subset of therapeutic classes, which make up the Formulary drug list.

**Preferred Providers** are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

**Qualifying Life Event** means an event that qualifies a Student to apply for coverage for him/herself or their dependents due to a Qualifying Life Event under the Certificate.

**Rehabilitative** means the process of restoring Your ability to live and work after a disabling condition by:

1. Helping You achieve the maximum possible physical and psychological fitness;
2. Helping You regain the ability to care for yourself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

**Reservist** means a member of a reserve component of the Armed Forces of the United States. Reservists also include a member of the State National Guard and the State Air National Guard.

**School or College** means the college or university attended by the Insured Student.

**Skilled Nursing Facility** – a facility, licensed, and operated as set forth in applicable state law, which:

1. mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24-hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial facility or a similar place.

**Sound, Natural Teeth** means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

**Stabilize** means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**Substance Use Disorder** means a condition that develops when an individual uses alcohol or other drug(s) in a way that damages their health and/or causes them to lose control of their actions. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Surgeon** means a Physician who actually performs surgical procedures.

**Telemedicine** means the practice of health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic mail message between a Physician and Insured Person constitutes "Telemedicine".

**Total Disability or Totally Disabled** means:

1. With respect to an Insured Person, who otherwise would be employed:
  - a. His or her complete inability to perform all the substantial and material duties of his or her regular occupation;
  - b. With care and Treatment by a Physician for the Covered Injury or Covered Sickness caused the inability.
2. With respect to an Insured Person who is not otherwise employed:
  - a. His or her inability to engage in the normal activities of a person of like age and sex; with
  - b. Care and Treatment by a Physician for the Covered Injury or Covered Sickness causing the inability; or
  - c. His or her Hospital Confinement or home Confinement at the direction of his or her Physician due to a Covered Injury or a Covered Sickness, except for visits to receive medical Treatment.

**Treatment** means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

**Urgent Care** means a medical problem that is an unexpected episode of illness or an injury requiring treatment which cannot reasonably be postponed for regularly scheduled care. It is not considered an Emergency. Urgent Care medical problems include, but are not limited to, ear ache, sore throat, and fever (not above 104 degrees). Treatment of an Urgent Care medical problem is not life threatening and does not require use of an emergency room at a Hospital. If you call your Physician prior to receiving care for an urgent medical problem and your Physician authorized you to go to an emergency room, your care will be paid at the level specified in the Schedule of Benefits for Emergency Room Services.

**Urgent Care Facility** means a Hospital or other licensed facility which provides diagnosis, Treatment, and care of persons who need acute care under the supervision of Physicians.

**Usual and Reasonable** means the average charge, in the absence of insurance, of the provider for a service or supply,

but not more than the prevailing charge in the area for a:

1. Like service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.

**You, or Your(s)** means an Insured Person, Insured Student, or Dependent of an Insured Student while insured under the Certificate.

**Visa**, means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid visa, either an F-1 (Academic), J-1 (Exchange) or M-1(Vocational) in order to continue as a student in the United States.

We, Us, or Our means Commercial Casualty Insurance Company or its authorized agent. Also referred to as the Company.

## Preferred Provider Organization (PPO) Network

By enrolling in this Insurance Program, you have the Cigna PPO Network of participating Providers with access to quality health care at discounted fees. To find a complete listing of the Network’s participating Providers, go to [www.cigna.com](http://www.cigna.com), or contact Consolidated Health Plans toll-free at (877) 657-5030, or [www.chpstudenthealth.com](http://www.chpstudenthealth.com) for assistance.

### Benefit Payments for Preferred Providers and Non-Preferred Providers

The Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. The Certificate provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

## Schedule of Benefits

### SCHEDULE OF BENEFITS

#### Preventive Services:

Preferred Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Preferred Allowance when services are provided through a Preferred Provider.

Non-Preferred Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Preferred Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Preferred Provider are not applied toward the annual Out-of-Pocket Maximum. Benefits are paid at 60% of the Usual and Reasonable charge.

<b>Deductible:</b> Preferred Provider	Individual: \$500 Family: \$1,000
Non-Preferred Provider	Individual: \$1,000 Family: \$2,000

#### Out-of-Pocket Maximum:

Preferred Provider:	Individual \$5,000 Family \$10,000
Non-Preferred Provider:	Individual \$8,000 Family \$16,000

#### Coinsurance Amount:

Preferred Provider:	80% of the Preferred Allowance (PA) for Covered Medical Expenses unless otherwise stated below.
Non-Preferred Provider:	60% of the Usual and Reasonable (U&R) charge for Covered Medical Expenses unless otherwise stated below.

## Pre-Certification Process

You should call the phone number found on the back of Your ID card for Pre-Certification. For Inpatient services or surgery, the call should be made at least 5 working days prior to Hospital Confinement or surgery. In the case of an emergency, the call should take place within two (2) working days of admission or as soon as reasonably possible.

The following Inpatient services or supplies require Pre-Certification:

1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of substance abuse, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. All partial hospitalization in a Hospital, residential Treatment facility, or facility established primarily for the Treatment of substance abuse;
4. Surgery

Pre-Certification is not required for a medical emergency or Urgent Care or Hospital Confinement for maternity care.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by Preferred or Non-Preferred providers.

Pre-Certification is not a guarantee that Benefits will be paid, this does not apply to electronic pre-certifications. We will not retrospectively deny if all criteria is met at the time the services are rendered.

Your Physician will be notified of Our decision as follows:

1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone, secure electronic transmission process, and/or in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing, secure electronic transmission process, or by telephone;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing, secure electronic transmission process, or by telephone regarding Our decision.

Our agent will make this determination within forty-eight (48) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. If additional information is needed to make a determination Our agent will notify Your Provider within 24 hours with the specific information that is required.

Notice of an Adverse Determination made by Our agent will be in writing or secure electronic transmission process and will include:

1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.
3. Notice of the availability, upon Your request, or Your designee, of the clinical review criteria relied upon to make the Adverse Determination.

Retro Review is permitted for a claim that is submitted for a service where Pre-Certification was required but not obtained if the service in question meets all of the following criteria:

1. The service is directly related to another service for which Pre-Certification was obtained and already performed;
2. The new service was not known to be needed at the time the original Pre-Certification was performed;
3. The need for the new service was revealed at the time the original authorized service was performed.

Once the request and all necessary information is received, the claim will be reviewed for coverage and medical necessity. The new service will not be denied based solely on the face that a Pre-Certification approval was not received originally.

Failure by Our agent to make a determination within the time periods prescribed above shall be deemed to be an Adverse Determination subject to an appeal or if a denial is received You can appeal their decision. Refer to the Appeals section of the Certificate.

If You has any questions about Your Pre-Certification status, You should contact Your Provider.

Urgent Care claims means a medical care or other service for a condition where application of the timeframe for making routine or non-life threatening care determinations is either of the following:

- a. Could seriously jeopardize the life, health, or safety of the patient or others due to the patient’s psychological state;
- b. In the opinion of a practitioner with knowledge of the patient’s medical or behavioral condition, would subject the patient to adverse health consequences without the care or treatment that is the subject of the request.

Urgent care requests can be submitted in writing or by a secure electronic transmission process (facsimile is not considered a secure electronic transmission).

**Benefit Payment for Preferred Providers and Non-Preferred Providers**

The Certificate provides benefits based on the type of health care provider selected. The Certificate provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

**Preferred Provider Organization:**

To locate a Preferred Provider in Your area, consult Your Provider Directory or call toll free (877) 657-5030 or visit Our website at [www.cigna.com](http://www.cigna.com).

**THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:**

1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A PREFERRED OR NON-PREFERRED PROVIDER.
4. COINSURANCE SHOWN BELOW REFLECTS THE PLAN COINSURANCE PERCENTAGE. THIS IS THE COINSURANCE AMOUNT THAT THE PLAN PAYS. THE INSURED IS RESPONSIBLE FOR PAYING ANY REMAINING COINSURANCE.
5. THE INSURED IS RESPONSIBLE FOR PAYING ANY COPAYMENTS SHOWN BELOW.
6. UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY, WITH THE EXCEPTION OF PREVENTIVE CARE SERVICES.

BENEFITS FOR COVERED INJURY/SICKNESS	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
<b>Inpatient Benefits</b>		
Hospital Room & Board Expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Preadmission Testing	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Physician’s Visits while Confined: Limited to one visit per day by any one doctor, when not related to surgery	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses



Inpatient Surgery: Pre-Certification required Surgeon Services	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Physical Therapy (inpatient) Limited to 60 visits per Policy Year Pre-Certification required	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Skilled Nursing Facility Expense Benefit Pre-Certification required Up to 90 Visits per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Benefit	Same as any other Covered Sickness	
Substance Use Disorder Benefit	Same as any other Covered Sickness	
<b>Outpatient Benefits</b>		
Outpatient Surgery: Surgeon Services	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

<p>Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, Physical Therapy, occupational therapy and speech therapy</p> <p>Cardiac Rehabilitation limited to 36 visits per Policy Year</p> <p>Pulmonary Rehabilitation limited to 20 visits per Policy Year, except if rendered as part of Physical Therapy, the Physical Therapy visit will apply</p> <p>Physical Therapy limited to 20 visits per Policy Year</p> <p>Occupational therapy limited to 20 visits per Policy Year</p> <p>Speech therapy limited to 20 visits per Policy Year</p> <p>Inhalation Therapy limited to 20 visits per Policy Year</p>	<p>80% of Preferred Allowance for Covered Medical Expenses</p>	<p>60% of Usual and Reasonable Charge for Covered Medical Expenses</p>
<p>Habilitative Services are covered to the extent that they are Medically Necessary – including services for children (up to age 21) with a medical diagnosis of Autism Spectrum Disorder.</p> <p>Clinical Therapeutic intervention, including but not limited to Applied Behavior Analysis, limited to 20 hours per week</p> <p>Physical Therapy limited to 20 visits per Policy Year</p> <p>Occupational therapy limited to 20 visits per Policy Year</p> <p>Speech and Language therapy limited to 20 visits per Policy Year</p>	<p>80% of Preferred Allowance for Covered Medical Expenses</p>	<p>60% of Usual and Reasonable Charge for Covered Medical Expenses</p>
<p>Emergency Services Expenses Includes Urgent Care expenses</p>	<p>80% of Preferred Allowance for Covered Medical Expenses Copayment: \$125 per visit Copayment waived if admitted</p>	<p>80% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: \$125 per visit Copayment waived if admitted</p>

Physician's Visits in Home or Office includes care by Urgent Care, primary Physician, specialist, consultant, and any other licensed practitioner operating within the scope of his or her license	80% of Preferred Allowance for Covered Medical Expenses Copayment: \$25	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: \$25
Urgent Care Centers or Facilities	80% of Preferred Allowance for Covered Medical Expenses Copayment: \$35	60% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Facility Fee	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Diagnostic Imaging Services	80% of Preferred Allowance for Covered Medical Expenses Copayment: \$25	60% of Usual and Reasonable Charge for Covered Medical Expenses
CT Scan, MRI and/or PET Scans	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of Preferred Allowance for Covered Medical Expenses Copayment: \$25	60% of Usual and Reasonable Charge for Covered Medical Expenses
<p><b>Prescription Drugs Retail Pharmacy</b> No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.</p> <p>No cost sharing applies for Orally Administered Cancer Chemotherapy when obtained from a Network Provider, Mail Order or Specialty Pharmacy (if applicable).</p> <p><b>Supply Limits</b> – We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost Sharing amount for up to a 30-day supply.</p>		
TIER 1 Generic	Copayment: \$15	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: \$15
TIER 2 Preferred Drug	Copayment: \$30	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: \$30
TIER 3 Non-Preferred Drug	Copayment: \$45	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: \$90
<p><b>Specialty Prescription Drugs</b></p>		
TIER 4 Specialty Prescription Drugs	Copayment: \$45	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: \$90

Tobacco cessation prescription and over-the-counter drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing below. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit <a href="http://www.cigna.com/pdf/ppaca-no-cost-share-preventive-medications.pdf">www.cigna.com/pdf/ppaca-no-cost-share-preventive-medications.pdf</a> or call (800) 325-1404.	100% of Preferred Allowance	
Tobacco cessation prescription drugs beyond the coverage above. Additional regimens of over-the-counter drugs are excluded.	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Home Health Care Expenses Up to 100 visits per Policy Year – limit does not apply to Infusion Therapy as provided under this benefit.	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Home Infusion Therapy	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospice Care Coverage	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Private-Duty Nursing in a home setting Up to 90 visits per Policy Year– limit does not apply to Infusion Therapy as provided under this benefit.	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Benefit	Same as any other Covered Sickness	
Substance Use Disorder Benefit	Same as any other Covered Sickness	
<b>Other Benefits</b>		
Allergy Testing	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Allergy Injections/Treatment	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Ambulance Service (including ground, water, fixed wing and rotary wing air transportation)	80% of Preferred Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses

Durable Medical Equipment	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Prosthetic and Orthotic Devices	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Routine Newborn Care	Same as any other Covered Sickness	
Nutritional Counseling	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Consultant/Specialist Physician Services when requested by the attending Physician	80% of Preferred Allowance for Covered Medical Expenses Copayment: \$35	60% of Usual and Reasonable Charge for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Accidental Injury Dental Treatment for Insured Persons Limited to \$3,000 per Injury per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses
Non-Routine Dental Services – including dental x-rays, supplies, and appliances and all associated expenses, including hospitalization and anesthesia. Limited to: <ul style="list-style-type: none"> <li>• facility charges for Outpatient services for the removal of teeth or for other dental processes only if the Covered Person’s medical condition or the dental procedure requires a Hospital setting to ensure the safety of the patient;</li> <li>• services/treatments for: transplant preparation; initiation immuno-suppressive; or direct treatment of acute traumatic injury, cancer, or cleft palate.</li> </ul>	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
<b>Pediatric Dental Care Benefit</b> Coverage is limited to covered persons through the end of the month in which the person turns 19.		
Preventive & Diagnostic services (Type A)	See Benefit for limitations 100% of Preferred Provider Coinsurance for Preventive Services	See Benefit for limitations 100% of the Usual and Reasonable Charge for Preventive Services
Basic Restorative services (Type B)	50% Usual and Reasonable	50% Usual and Reasonable
Major and General services (Type C)	50% Usual and Reasonable	50% Usual and Reasonable
Medically Necessary Orthodontia services (Type D)	50% Usual and Reasonable	50% Usual and Reasonable

<b>PREVENTIVE AND DIAGNOSTIC SERVICES (TYPE A)</b>
<b>Diagnostic and Treatment Services:</b>
Periodic oral evaluation- Limited to 1 every 6 months
Limited oral evaluation- problem focused- Limited to 1 every 6 months
Comprehensive oral evaluation- Limited to 1 every 6 months
Comprehensive periodontal evaluation- Limited to 1 every 6 months
Intraoral-complete series (including bitewings) 1 every 60 (sixty) months film
Intraoral- periapical first
Intraoral- periapical - each additional film
Intraoral- occlusal film
Bitewing- single film 1 set every 6 months
Bitewings -two films 1 set every 6 months
Bitewings - four films 1 set every 6 months
Vertical bitewings-7 to 8 films 1 set every 6 months
Panoramic film-1 film every 60 (sixty) months
Cephalometric x-ray
Oral/ Facial Photographic Images
Diagnostic Models
<b>Preventative Services:</b>
Prophylaxis-Child- Limited to 1 every 6 months
Topical application of fluoride (excluding prophylaxis)--Limited to 2 every 12 months
Topical application of fluoride (excluding prophylaxis)- 2 every 12 months
Topical fluoride varnish- 2 in 12 months
Sealant- per tooth- unrestored permanent molars - 1 sealant per tooth every 36 months
Preventative resin restorations in a moderate to high caries risk patient- permanent tooth- 1 sealant per tooth
Space maintainer-fixed -unilateral
Space maintainer-fixed- bilateral
Space maintainer-removable-unilateral
Space maintainer-removable-bilateral
Re-cementation of space maintainer
<b>Additional Procedures covered as Preventive and Diagnostic:</b>
Palliative treatment of dental pain- minor procedure
<b>BASIC RESTORATIVE SERVICES (TYPE B)</b>
<b>Minor Restorative Services:</b>
Amalgam- one surface, primary or permanent
Amalgam- two surfaces, primary or permanent
Amalgam- three surfaces, primary or permanent
Amalgam- four or more surfaces, primary or permanent
Resin-based composite - one surface, anterior
Resin-based composite -two surfaces, anterior
Resin-based composite -three surfaces, anterior
Resin-based composite- four or more surfaces or involving incisal angle (anterior)
Re-cement inlay
Re-cement crown
Prefabricated stainless steel crown- primary tooth - Limited to 1 per tooth in 60 months
Prefabricated stainless steel crown - permanent tooth - Limited to 1 per tooth in 60 months
Protective Restoration
Pin retention per tooth, in addition to restoration
<b>Endodontic Services:</b>
Therapeutic pulpotomy (excluding final restoration)- <i>If a root canal is within 45 days of the pulpotomy, the</i>
Partial pulpotomy for apexogenesis- permanent tooth with incomplete root development <i>If a root canal is within</i>
Pulpal therapy (resorbable filling)- anterior, primary tooth (excluding final restoration) • <i>Limited to primary incisor</i>
Pulpal therapy (resorbable filling)- posterior, primary tooth excluding final restoration). Incomplete endodontic
<b>Periodontal Services:</b>
Periodontal scaling and root planing-four or more teeth per quadrant- Limited to 1 every 24 months
Periodontal scaling and root planing-one to three teeth, per quadrant- Limited to 1 every 24 months
Periodontal maintenance- 4 in 12 months combined with adult prophylaxis after the completion of active

<b>Prosthodontic Services:</b>
Adjust complete denture-maxillary
Adjust complete denture-mandibular
Adjust partial denture-maxillary
Adjust partial denture-mandibular
Repair broken complete denture base
Replace missing or broken teeth complete denture (each tooth)
Repair resin denture base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth- per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete maxillary denture- Limited to 1 in a 36-month period 6 months after the initial installation
Rebase maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Rebase mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture -Limited to 1 in a 36-month Period 6 months after the initial installation
Reline complete mandibular denture -Limited to 1 in a 36-month period 6 months after the initial installation
Reline maxillary partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture- Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture (laboratory) -Limited to 1 in a 36-month period 6 months after the initial
Reline complete mandibular denture (laboratory)- Limited to 1 in a 36-month period 6 months after the initial
Reline maxillary partial denture (laboratory)-Limited to 1 in a 36-month period 6 months after the initial
Reline mandibular partial denture (laboratory) Rebase/Reline- Limited to 1 in a 36-month period 6 months after
Tissue conditioning (maxillary)
Tissue conditioning (mandibular)
Re-cement fixed partial denture
Fixed partial denture repair, by report
<b>Oral Surgery:</b>
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section
Removal of impacted tooth - soft tissue
Removal of impacted tooth- partially bony
Removal of impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)
Coronectomy- intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Surgical access of an unerupted tooth
Alveoplasty in conjunction with extractions - per quadrant
Alveoplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Alveoplasty not in conjunction with extractions- per quadrant
Alveoplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess intraoral soft tissue
Suture of recent small wounds up to 5 cm
Excision of pericoronal gingiva
<b>MAJOR SERVICES (TYPE C)</b>
<b>Major Restorative Services:</b>
Detailed and extensive oral evaluation- problem focused, by report
Inlay- metallic- one surface- An alternate benefit will be provided
Inlay- metallic- two surfaces -An alternate benefit will be provided
Inlay- metallic-three surfaces -An alternate benefit will be provided
Onlay- metallic- two surfaces- Limited to 1 per tooth every 60 months
Onlay - metallic- three surfaces- Limited to 1 per tooth every 60 months
Onlay - metallic- four or more surfaces- Limited to 1 per tooth every 60 months
Crown- porcelain/ceramic substrate- Limited to 1 per tooth every 60 months

Crown- porcelain fused to high noble metal- Limited to 1 per tooth every 60 months
Crown- porcelain fused to predominately base metal-Limited to 1 per tooth every 60 months
Crown- porcelain fused to noble metal-Limited to 1 per tooth every 60 months
Crown - 3/4 cast high noble metal- Limited to 1 per tooth every 60 months
Crown - 3/4 cast predominately base metal- Limited to 1 per tooth every 60 months
Crown - 3/4 porcelain/ceramic- Limited to 1 per tooth every 60 months
Crown - full cast high noble metal- Limited to 1 per tooth every 60 months
Crown- full cast predominately base metal-Limited to 1 per tooth every 60 months
Crown - full cast noble metal- Limited to 1 per tooth every 60 months
Crown-titanium- Limited to 1 per tooth every 60 months
Core buildup, including any pins- Limited to 1 per tooth every 60 months
Prefabricated post and core, in addition to crown- Limited to 1 per tooth every 60 months
Crown repair, by report
<b>Endodontic Services:</b>
Anterior root canal (excluding final restoration)
Bicuspid root canal (excluding final restoration)
Molar root canal (excluding final restoration)
Retreatment of previous root canal therapy-anterior
Retreatment of previous root canal therapy-bicuspid
Retreatment of previous root canal therapy-molar
Apexification/recalcification- initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification- interim medication replacement (apical closure/calcific repair of perforations, root
Apexification/recalcification- final visit (includes completed root canal therapy, apical closure/calcific repair of
Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp)
Apicoectomy/periradicular surgery- anterior
Apicoectomy/periradicular surgery- bicuspid (first root)
Apicoectomy/periradicular surgery -molar (first root)
Apicoectomy/periradicular surgery (each additional root)
Root amputation- per root
Hemisection (including any root removal)- not including root canal therapy
<b>Periodontal Services:</b>
Gingivectomy or gingivoplasty- four or more teeth-Limited to 1 every 36 months
Gingivectomy or gingivoplasty-one to three teeth
Gingival flap procedure, four or more teeth-Limited to 1 every 36 months
Clinical crown lengthening-hard tissue
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per
Pedicle soft tissue graft procedure
Free soft tissue graft procedure (including donor site surgery)
Subepithelial connective tissue graft procedures (including donor site surgery)
Full mouth debridement to enable comprehensive evaluation and diagnosis
<b>Prosthetic Services:</b>
Complete denture - maxillary-Limited to 1 every 60 months
Complete denture- mandibular-Limited to 1 every 60 months
Immediate denture- maxillary-Limited to 1 every 60 months
Immediate denture- mandibular-Limited to 1 every 60 months
Maxillary partial denture- resin base (including any conventional clasps, rests and teeth)- Limited to 1 every 60
Mandibular partial denture- resin base (including any conventional clasps, rests and teeth)-Limited to 1 every 60
Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, rests
Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps,
Removable unilateral partial denture-one piece cast metal (including clasps and teeth)-Limited to 1 every 60
Endosteal Implant- 1 every 60 months
Surgical Placement of Interim Implant Body- 1 every 60 months
Epoosteal Implant- 1 every 60 months
Transosteal Implant. Including Hardware- 1 every 60 months
Implant supported complete denture
Implant supported partial denture
Connecting Bar-implant or abutment supported- 1 every 60 months



Prefabricated Abutment- 1 every 60 months
Abutment supported porcelain ceramic crown - 1 every 60 months
Abutment supported porcelain fused to high noble metal- 1 every 60 months
Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months
Abutment supported porcelain fused to noble metal crown 1 every 60 months
Abutment supported cast high noble metal crown - 1 every 60 months
Abutment supported cast predominately base metal crown – 1 every 60 months
Abutment supported Cast noble metal crown 1 every 60 months
Implant supported porcelain/ceramic crown- 1 every 60 months
Implant supported porcelain fused to high metal crown - 1 every 60 months
Implant supported metal crown- 1 every 60 months
Abutment supported retainer for porcelain/ceramic fixed partial denture- 1 every 60 months
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60
Abutment supported retainer for porcelain fused to noble metal fixed partial denture- 1 every 60 months
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast noble metal fixed partial denture- 1 every 60 months
Implant supported retainer for ceramic fixed Partial denture- 1 every 60 months
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
Implant/abutment supported fixed partial denture for partially edentulous arch- 1 every 60 months
Implant Maintenance Procedures -1 every 60 months
Repair Implant Prosthesis -1 every 60 months
Replacement of Semi-Precision or Precision Attachment- 1 every 60 months
Repair Implant Abutment -1 every 60 months
Implant Removal-1 every 60 months
Implant Index -1 every 60 months
Pontic-cast high noble metal- Limited to 1 every 60 months
Pontic-cast predominately base metal -Limited to 1 every 60 months
Pontic-cast noble metal- Limited to 1 every 60 months
Pontic-titanium-Limited to 1 every 60 months
Pontic -porcelain fused to high noble metal-Limited to 1 every 60 months
Pontic-porcelain fused to predominately base metal-Limited to 1 every 60 months
Pontic-porcelain fused to noble metal Limited to 1 every 60 months
Pontic-porcelain/ceramic-Limited to 1 every 60 months
Inlay/on lay- porcelain/ceramic-Limited to 1 every 60 months
Inlay-metallic-two surfaces-Limited to 1 every 60 months
Inlay- metallic-three or more surfaces- Limited to 1 every 60 months
Onlay- metallic- three surfaces- 1 every 60 months
Onlay- metallic- four or more surfaces -1 every 60 months
Retainer -cast metal for resin bonded fixed prosthesis -1 every 60 months
Retainer- porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
Crown- porcelain/ceramic- 1 every 60 months
Crown -porcelain fused to high noble metal - 1 every 60 months
Crown- porcelain fused to predominately base metal- 1 every 60 months
Crown- porcelain fused to noble metal - 1 every 60 months
Crown -3/4 cast high noble metal - 1 every 60 months
Crown- 3/4 cast predominately base metal • 1 every 60 months
Crown 3/4 cast noble metal 1 every 60 months
Crown - 3/4 porcelain/ceramic- 1 every 60 months
Crown • full cast high noble metal- 1 every 60 months
Crown -full cast predominately base metal- 1 every 60 months
Crown full cast noble metal 1 every 60 months
Core build up for retainer including any pins 1 every 60 months
Occlusal guard, by report- 1 in 12 months

<b>GENERAL SERVICES (TYPE C)</b>		
<b>Anesthesia Services:</b>		
Deep sedation/general anesthesia- first 30 minutes		
Deep sedation/general anesthesia- each additional 15 minutes		
<b>Intravenous Sedation:</b>		
Intravenous conscious sedation/analgesia- first 30 minutes		
Intravenous conscious sedation/analgesia each additional 15 minutes		
<b>Consultations:</b>		
Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)		
<b>Medications:</b>		
Therapeutic drug injection, by report		
<b>Post-Surgical Services:</b>		
Treatment of complications (post-surgical) unusual circumstances, by report		
<b>MEDICALLY NECESSARY ORTHODONTIA SERVICES (TYPE D)</b>		
<b>Orthodontic Services -covered for persons with severe and handicapping malocclusion</b>		
Limited orthodontic treatment of the primary dentition		
Limited orthodontic treatment of the transitional dentition		
Limited orthodontic treatment of the adolescent dentition		
Interceptive orthodontic treatment of the primary dentition		
Interceptive orthodontic treatment of the transitional dentition		
Comprehensive orthodontic treatment of the transitional dentition		
Comprehensive orthodontic treatment of the adolescent dentition		
Removable appliance therapy		
Periodic orthodontic treatment visits (as part of contract)		
Orthodontic retention (removal of appliances, construction and placement of retainer(s))		
<b>Pediatric Vision Care</b>		
Pediatric Vision Care Benefit (including low vision services) limited to Insured Person's to the end of the month in which the person turns 19 Limited to 1 visit per Policy Year and 1 pair of prescribed lenses and frames per Policy Year	100% of Preferred Allowance for Covered Medical Expenses	
Manipulation Therapy Benefit Subject to a maximum number of visits of 12 per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Organ Transplant Surgery Donor's search for bone marrow/stem cell transplants limited to \$30,000 per Transplant Maximum benefit payable for travel and lodging expenses for any one transplant \$10,000	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Reconstructive Surgery	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Telemedicine or Telehealth Service	80% of Preferred Allowance for Covered Medical Expenses Copayment: \$25 per visit	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: \$25 per visit
Chemotherapy and Radiation Therapy Including orally administered cancer drugs	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

Diabetic Equipment, Education and Supplies	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
<b>Mandated Benefits</b>		
Child Health Supervision Services, when Dependent Coverage is part of the Certificate.	Same as any other Covered Sickness, subject to the limitations described in the Benefit, unless considered a Preventive Service	
Cytologic Screening and Mammography	Same as any other Covered Sickness, subject to the limitations described in the Benefit, unless considered a Preventive Service	
Dialysis	Same as any other Covered Sickness	
<b>OPTIONAL RIDERS</b>		
Medical Evacuation Expense	100% of Usual and Reasonable Charge for Covered Medical Expenses Subject to \$50,000 maximum per Policy Year	
Repatriation Expense	100% of Usual and Reasonable Charge for Covered Medical Expenses Subject to \$50,000 maximum per Policy Year	
Registered Nurse Services for private duty nursing while Confined Pre-Certification required	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

**OPTIONAL BENEFIT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

Principal Sum for Double Dismemberment or Loss of Life .....\$10,000

Loss must occur with 90 days of the date of a covered Accident.

If, as the result of a covered Accident, You sustain any of the following losses within the time shown in the Schedule of Benefits, We will pay the benefit shown.

- Loss of Life .....The Principal Sum
- Loss of hand..... One-Half the Principal Sum
- Loss of Foot.....One-Half the Principal Sum
- Loss of either one hand, one foot or sight of one eye..... One-half the Principal Sum
- Loss of more than one of the above losses due to one Accident.....The Principal Sum

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The Principal Sum is the largest amount payable under this benefit for all losses resulting from any one Accident.

**Medical Evacuation and Repatriation**

The maximum benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits.

**Medical Evacuation Expense - If:**

- a. An Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness;
  - b. Evacuation that occurs while he or she is covered under the Certificate,
- We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

- a. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five or more consecutive days immediately prior to medical evacuation;
- b. Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved the medical evacuation;
- c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;
- d. No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person's insurance terminates except with respect to any expenses payable under the Extension of Benefit provision; However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination;
- e. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Certificate for Insured Person; and
- f. Transportation must be by the most direct and economical route.

**Repatriation Expense** - If the Insured Person dies while he or she is covered under this Policy, We will pay a benefit. The benefit will be the necessary Usual and Reasonable charges for preparation, including cremation, and transportation of the remains to the Insured Person's place of residence in his or her Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

## Exclusions

### Skilled Nursing Facility

**Exclusions** under this benefit include:

- a. Custodial Care service and supplies,
- b. Confinement for Custodial Care or residential care

### Prescription Drugs

**Exclusions** under this Prescription Drug benefit for any drug or medicine:

- a. Prescription Drugs dispensed by any Mail Service program other than the PBM's mail Service, unless prohibited by law, except as required for Preventive Care Services and unless covered elsewhere in the Certificate.
- b. Drugs, devices and products, or Prescription Legend Drugs with over the counter equivalents and any Drugs, devices or products that are therapeutically comparable to an over the counter Drug, device, or product, except as required for Preventive Care Services.
- c. Off label use, except as otherwise prohibited by law.
- d. Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- e. Drugs not approved by the FDA.
- f. Charges for the administration of any Drug.
- g. Drugs consumed at the time and place where dispensed or where the Prescription Order is issued, including but not limited to samples provided by a Physician. This does not apply to Drugs used in conjunction with a Diagnostic Service, with Chemotherapy performed in the office or Drugs eligible for coverage under the Medical Supplies benefit; they are Covered Services.
- h. Any Drug which is primarily for weight loss.
- i. Drugs not requiring a prescription by federal law (including Drugs requiring a prescription by state law, but not by federal law), except for injectable insulin.
- j. Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- k. Fertility Drugs, unless covered elsewhere in the Certificate.
- l. Contraceptive devices, oral immunizations, and biologicals, although they are federal legend Drugs, are payable as medical supplies based on where the service is performed or the item is obtained. If such items are over the counter Drugs, devices or products, they are not Covered Services, unless such over the counter methods are prescribed by a Physician.
- m. Drugs in quantities which exceed the limits established by the Plan.
- n. Compound Drugs unless there is at least one ingredient that requires a prescription.

- o. Treatment of Onchomycosis (toenail fungus).
- p. Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter except for Preventive Services.
- q. Brand-Name Prescription Drugs with generic equivalents.

### **Orthotic Devices**

#### **Exclusions**

- a. Orthopedic shoes (except therapeutic shoes for diabetics)
- b. Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace.
- c. Standard elastic stockings, garter belts, and other supplies not specially made and fitted.

### **Accidental Injury Dental Treatment for Insured Persons**

#### **Exclusions** under this benefit:

- a. orthodontic braces and orthodontic appliances.
- b. routine dental care and treatment

### **Manipulation Therapy**

#### **Exclusions**

This benefit does not cover charges incurred for:

- a. Acupuncture,
- b. heat Treatment,
- c. diathermy,
- d. massage, in any form, except to the extent provided in the Schedule of Benefits.

### **Organ Transplant Surgery**

#### **Donor's Surgery**

#### **Exclusions**

This benefit does not cover:

- a. Routine harvesting and storage of stem cells from newborn cord blood;
- b. The purchase price of any organ or tissue;
- c. Donor services if the recipient is not an Insured Person under this plan;
- d. Services for or related to the transplantation of animal or artificial organs or tissues;
- e. The transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be Covered under another health plan or program.

### **Travel Expenses**

#### **Exclusions**

Non-Covered Services for transportation and lodging include, but are not limited to:

- a. Child care;
- b. Mileage within the medical transplant facility city;
- c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
- d. Frequent flyer miles;
- e. Coupons, vouchers, or travel tickets;
- f. Prepayments or deposits;
- g. Services for a condition that is not directly related or a direct result of the transplant;
- h. Telephone calls;
- i. Laundry;
- j. Postage;
- k. Entertainment;
- l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
- m. Travel expenses for donor companion/caregiver;
- n. Return visits for the donor for a Treatment of condition found during the evaluation.

**Exclusion Disclaimer:** Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

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

1. Which are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
2. Received from an individual or entity that is not a Provider, as defined in the Certificate, or recognized by Us.
3. Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
4. For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers' Compensation Act or other similar law. If Workers' Compensation Act benefits are not available to an Insured Person, then this Exclusion does not apply. This exclusion applies if the Insured Person receives the benefits in whole or in part. This exclusion also applies whether or not the Insured Person claims the benefits or compensation.
5. To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
6. For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
7. For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
8. For court ordered testing or care unless Medically Necessary.
9. For which an Insured Person has no legal obligation to pay in the absence of this or like coverage.
10. For the following:
  - Physician or Other Practitioners' charges for consulting with Insured Persons by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Insured Person except as otherwise described in the Certificate.
  - Surcharges for furnishing and/or receiving medical records and reports.
  - Charges for doing research with Providers not directly responsible for an Insured Person's care.
  - Charges that are not documented in Provider records.
  - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
  - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
11. Received from a dental or medical department maintained by or on behalf of a School, mutual benefit association, labor union, trust or similar person or group.
12. Prescribed, ordered or referred by or received from a member of an Insured Person's immediate family, including an Insured Person's spouse, child, brother, sister, parent, in-law, or self.
13. For completion of claim forms or charges for medical records or reports unless otherwise required by law.
14. For missed or canceled appointments.
15. For mileage, lodging and meals costs, and other Insured Person travel related expenses, except as specifically stated as a Covered Service.
16. For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if an Insured Person had applied for Parts A, B and/or D, except, as specified elsewhere in the Certificate or as otherwise prohibited by federal law, as addressed in the section titled "Medicare" in General Provisions. For the purposes of the calculation of benefits, if the Insured Person has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.
17. Charges in excess of Our Maximum Usual and Reasonable.
18. Incurred prior to an Insured Person's Effective Date.
19. Incurred after the termination date of this coverage except as specified elsewhere in the Certificate.

20. For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve an Insured Person's appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of an Insured Person's skin or to change the size, shape or appearance of facial or body features (such as an Insured Person's nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Insured Person was covered by another carrier/self funded plan prior to coverage under the Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
21. For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves an Insured Person's present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
22. For the following:
- Custodial Care, convalescent care or rest cures.
  - Domiciliary care provided in a residential institution, (except for Mental Health Disorder and Substance Use Disorder treatment), treatment center, halfway house, or school because an Insured Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
  - Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
  - Care provided or billed by a residential facility (except for Mental Health Disorder and Substance Use Disorder treatment), including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
  - Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
  - Wilderness camps.
23. For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
- cleaning and soaking the feet.
  - applying skin creams in order to maintain skin tone.
  - other services that are performed when there is not a localized illness, injury or symptom involving the foot.
24. For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
25. Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in the Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
26. For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that result in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous plan, and it applies if the surgery was performed while the Insured Person was covered by a previous carrier/self-funded plan prior to coverage under the Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of co-morbid medical conditions during the procedure or in the immediate post-operative time frame.

27. For marital counseling.
28. For hearing aids or examinations to prescribe/fit them, unless otherwise specified within the Certificate.
29. For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
30. For services to reverse voluntarily induced sterility.
31. For diagnostic testing or treatment related to infertility.
32. For personal hygiene, environmental control, or convenience items including but not limited to:
  - Air conditioners, humidifiers, air purifiers;
  - Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor's meals;
  - charges for non-medical self-care except as otherwise stated;
  - Purchase or rental of supplies for common household use, such as water purifiers;
  - Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
  - Infant helmets to treat positional plagiocephaly;
  - Safety helmets for Insured Persons with neuromuscular diseases; or
  - Sports helmets.
33. Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
34. For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or as otherwise described in the Certificate.
35. For care received in an emergency room which is not Emergency Care, except as specified in the Certificate. This includes but is not limited to suture removal in an emergency room.
36. For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
37. For self-help training and other forms of non-medical self-care, except as otherwise provided in the Certificate.
38. For examinations relating to research screenings.
39. For stand-by charges of a Physician.
40. Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes except as required under Preventive Services.
41. For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
42. For Manipulation Therapy services rendered in the home as part of Home Care Services.
43. Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
44. For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergal synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
45. For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
46. For surgical treatment of gynecomastia.
47. For treatment of hyperhidrosis (excessive sweating).
48. Complications directly related to a service or treatment that is a non-Covered Service under the Certificate because it was determined by Us to be Experimental/Investigational or non- Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non- Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non- Medically Necessary service.



49. For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply, except as required for Preventive Care Services. Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
50. Treatment of telangiectatic dermal veins (spider veins) by any method.
51. Reconstructive services except as specifically stated in the **Covered Services** section of the Certificate, or as required by law.
52. Nutritional and/or dietary supplements, except as provided in the Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.
53. **International Students Only** - Eligible expenses within the Insured Person's 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.
54. Dental Implants, except for the benefit covered under the Pediatric Dental benefit, unless covered elsewhere in the Certificate.
55. Human Growth Hormone for children born small for gestational age.
56. Prescriptions, fitting, or purchase of eyeglasses or contact lenses, except for benefits provided under Pediatric Vision, and except in the case of Injury or as otherwise provided and unless covered elsewhere in the Certificate.
57. Vision correction surgery, Orthoptic Therapy, visual training or radial keratotomy or similar surgical procedures to correct vision (including LASIK, radial keratotomy or keratomileusis), except as provided herein or when due to a disease process. This Exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery for treatment of cataract or aphakia, contact lenses or glasses following lens implantation.

## Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

## Right of Recovery

If the amount of payments made by Our Agent or Us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

## Right to Subrogation

If the Insured Person suffers an Injury or Covered Sickness through the act or omission of another person, and if benefits are paid under this Policy due to such Injury or Covered Sickness, then We will be entitled to a refund of benefits We have paid from such recovery, as permitted by law. The refund of benefits shall be allowable to the extent the Insured Person recovers or may recover for the same Injury or Covered Sickness from another plan, including a third party, its insurer, or the Insured Person's uninsured motorist insurance. Further, We have the right to offset subsequent benefits payable to the Insured Person under the Policy against such recovery in the event the Insured Person has not cooperated with previous attempts to recover.

Upon Our request, the Insured Person must complete the required forms and return them to Us or to Our administrator. The Insured Person must notify Us of any pending or contemplated claims against third parties. The

Insured Person must cooperate fully with Us in asserting a right to recover. The Insured Person will be personally liable for reimbursement to Us to the extent of any recovery obtained by the Insured Person from any third party. If it is necessary for Us to institute legal action against the Insured Person for failure to repay Us, the Insured Person will be personally liable for all costs of collection, including reasonable attorney's fees.

We may file a lien in an Insured Person's action against the third party and have a lien upon any recovery that the Insured Person receives whether by settlement, judgment, or otherwise, and regardless of how such funds are designated. If the Insured Person recovers less than the amount we are owed, The Insured Person will only owe us what they recover. However, the amount the Insured Person owes us will be diminished in the same proportion as their amount was diminished, as described in Ohio Revised Code section 2323.44.

**Limitation to Our Recovery Rights:** We may exercise Our Right to Subrogation against third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under this plan. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a third party.

## Claim Procedures

### In the event of either an Injury or a Sickness:

1. Report to a Physician, Hospital or the School's Student Health Services.
2. Written notice of a claim must be submitted to the address below within 90 days after the date of Injury or commencement of Sickness covered by the Certificate, or as soon thereafter as is reasonably possible.
3. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim. Bills should be received by the Company within 90 days of service.

**CIGNA**  
**PO Box 188061**  
**Chattanooga, TN 37422 – 8061**  
 Electronic Payor ID: 62308

For information about the Cigna Prescription Drug Program please visit [www.cigna.com](http://www.cigna.com).

## Claim Appeal Process

### Internal Appeals

An initial determination by Us can be appealed for internal review. The Plan will advise you of your rights to appeal to the next level if a denial occurs after an initial determination.

You have the right to designate a representative (e.g. your Physician) to file appeals with Us on your behalf and to represent you in any level of the appeals process. If a representative is seeking an appeal on your behalf, We must obtain a signed Designation of Representation (DOR) form from you. The appeal process will not begin until We have received the properly completed DOR form except that if a Physician requests expedited review of an appeal on your behalf, the Physician will be deemed to be your designee for the limited purpose of filing for expedited review of the appeal without receipt of a signed form. We will forward a Designation of Representation form to you for completion in all other situations.

We will accept oral or written comments, documents or other information relating to an appeal from the Covered Person or the Covered Persons Provider by telephone, secure electronic transmission process (facsimile is not considered a secure electronic transmission) or other reasonable means. Covered Persons are entitled to receive, upon request and free of charge, reasonable access to, and copies of, documents, records, and other information relevant to the Covered Person's appeal.

To obtain information on Our appeal procedures or to file an oral appeal please call the toll free customer service number listed on the back of your Identification Card or the number provided for appeals on any written notice of an adverse decision that you receive from Us.

We will also accept appeals filed in writing. If you wish to file your appeal in writing, you must mail it to: Consolidated Health Plans at 2077 Roosevelt Avenue, Springfield, MA 01104; toll-free 877-657-5030; website: [www.chpstudenthealth.com](http://www.chpstudenthealth.com) or to the address provided for filing an appeal on any written notice of an adverse decision that you receive from Us.

We expect that you will use good faith to file an appeal on a timely basis. However, We will not review an appeal if it is received by Us after 180 days have passed since the incident leading to your appeal.

**Claims Administrator:  
Consolidated Health Plans (CHP)  
2077 Roosevelt Avenue  
Springfield, Massachusetts 01104  
(877) 657-5030  
[www.chpstudenthealth.com](http://www.chpstudenthealth.com)**

**The Student Health Insurance Plan is underwritten by:  
Commercial Casualty Insurance Company  
Fort Wayne, IN**

**As Policy form: OH SHIP CERT (2018) et al**

**For a copy of the Company's privacy notice you may go to:**  
[www.consolidatedhealthplan.com/about/hipaa](http://www.consolidatedhealthplan.com/about/hipaa)  
(Please indicate the school you attend with your written request)  
or  
Request one from the Health Office at your School

***Representations of the Plan must be approved by the Company.***

This is not the Certificate. Rather, it is a brief description of the benefits and other provisions of the Certificate. The Certificate is governed by the laws and regulations of the state in which it is issued and is subject to any necessary State approvals. Any provisions of the Certificate, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits.

## Value Added Services

The following are not affiliated with Commercial Casualty Insurance Company and the services are not part of the Plan Underwritten by Commercial Casualty Insurance Company. These value-added options are provided by Consolidated Health Plans.

### **VISION DISCOUNT PROGRAM**

For Vision Discount Benefits please go to:

[www.chpstudenthealth.com](http://www.chpstudenthealth.com)

### **EMERGENCY MEDICAL AND TRAVEL ASSISTANCE**

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at (877) 657-5030. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 or if you are in a foreign country, call collect at: (715) 295-9311.** When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

### **24 HOUR NURSELINE**

Students who enroll and maintain medical coverage in this insurance plan have access to the *24 Hour Nurseline*. This *24-Hour Nurseline* program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The *Nurseline* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *24 Hour Nurseline* toll free number will be on the ID card.

**(800) 634-7629**



Your out-of-pocket costs may be lower when you utilize Cigna PPO Providers. For a listing of Cigna PPO Providers, go to [www.cigna.com](http://www.cigna.com) or contact Consolidated Health Plans toll-free at (877) 657-5030, or [www.chpstudenthealth.com](http://www.chpstudenthealth.com) for assistance.



With CareConnect from CHP Student Health, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, **(888) 857-5462**, or via the CHP Student Health mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.