

Northeast Ohio Medical University

2018-2019 Student Health Plan

Group No: ST1275SH

Policy No: CCIC1819OHSHIP25

Dear Students:

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

Who Is Eligible To Enroll?

All registered College of Medicine and College of Pharmacy students taking at least 1 credit are required to have health insurance, either through this Student Health Insurance Plan or through another individual or family plan.

All registered Graduate students taking at least 1 credit are eligible to enroll on a voluntary basis.

How Do I Enroll?

All registered College of Medicine and College of Pharmacy students taking at least 1 credit are automatically enrolled in the Plan unless proof of comparable coverage is provided by completing a waiver.

All registered Graduate students taking at least 1 credit can enroll by going to

<https://link.zixcentral.com/u/aae7ffc4/RIW4BWIY6BGoBf0h3soMg?u=http%3A%2F%2Fwww.haylor.com%2Fcollege%2Fnortheast-ohio-medical-university>

How Do I Waive Coverage?

All registered College of Medicine and College of Pharmacy Students taking at least 1 credit can waive by providing proof of comparable coverage at www.haylor.com. Select your College/University and choose the waiver option that applies.

Waiver Period Deadline Dates

New Students Fall	July 30, 2018
2 nd – 4 th Year Fall	July 30, 2018

Cost and Periods of Coverage* New Students

	10 Month 8/27/18-6/30/19*	Fall 8/27/18-12/31/18*	Spring 1/1/19-6/30/19*
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 fee.
Dependent rates are in addition to the student rate.

Cost and Periods of Coverage* 2nd-4th Year Students

	Annual 7/1/18-6/30/19*	Fall 7/1/18-12/31/18*	Spring/Summer 1/1/19-6/30/19*
Student	\$2,557	\$1,289	\$1,268
Spouse	\$2,557	\$1,289	\$1,268
Each Child	\$2,557	\$1,289	\$1,268
3 or More Children	\$7,671	\$3,867	\$3,804

*The above rates include an administrative fee.
Dependent rates are in addition to the student rate.

HEALTH INSURANCE BENEFIT SUMMARY*

BENEFIT	NETWORK	NON-NETWORK
Benefit Maximum	Unlimited	
Annual Deductible	\$500 Individual \$1,000 Family	\$1,000 Individual \$2,000 Family
Out-of-Pocket Maximum	\$5,000 Individual \$10,000 Family	\$8,000 Individual \$16,000 Family
Coinsurance	80% of PA	60% of U&R
Preventive Care	100% of PA (no cost sharing)	60% of U&R
Hospital Room & Board (Inpatient)**	80% of PA	60% of U&R
Surgery (Inpatient or Outpatient)	80% of PA	60% of U&R
Physician Visits in Home or Office Telemedicine or Telehealth	80% of PA, after Copayment: \$25	60% of U&R Copayment: \$25
Consultant/Specialist Physician Services when requested by the attending Physician	80% of PA Copayment: \$35	60% of U&R
Emergency Services Expense	80% of PA, after \$125 copay per visit Copay waived if admitted	80% of U&R, after \$125 copay per visit Copay waived if admitted
Urgent Care Centers or Facilities	80% of PA, after Copayment: \$35	60% of U&R
Diagnostic Imaging Services	80% of PA Copayment: \$25	60% of U&R
Mental Health and Substance Abuse	Same as any Sickness	Same as any Sickness
Outpatient Prescription Drugs (Non-Network benefits provided on a reimbursement basis)	100% of PA, after: \$15 copay Generic \$30 copay Preferred Brand \$45 copay non-Preferred Brand \$45 copay Specialty (copay per drug)	60% U&R, after: \$15 copay Generic \$30 copay Preferred Brand \$90 copay non-Preferred Brand \$90 copay Specialty (copay per drug)

PA= Preferred Allowance U&R=Usual and Reasonable

*This is only a brief description of the coverage(s) available under Certificate form OH SHIP CERT (2018). The Certificate will contain the reductions, limitations, exclusions and termination provisions. Full details of coverage are contained in the Certificate. If there are any conflicts between this document and the Certificate, the Certificate shall govern in all cases.

**All inpatient confinements require pre-certification. The phone number can be found on the back of the Insured's ID card. The call should be made prior to Hospital Confinement. In the case of an emergency, the call should take place as soon as reasonably possible

Underwritten By:
Commercial Casualty Insurance Company

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

Servicing Agent:
Haylor, Freyer & Coon, Inc
P O Box 4743
231 Salina Meadows
Pkwy Syracuse, NY 13212
866-535-0456

Where Can I Obtain More Information About The Plan?

Enroll Dependents Insurance Benefits Claim Processing ID Cards	Consolidated Health Plans (CHP) www.chpstudenthealth.com
Waiving the Plan	www.haylor.com
Find Network Provider	CHP or CIGNA www.chpstudenthealth.com or www.cigna.com
Find Prescription Drug Provider	Cigna Pharmacy Network www.cigna.com

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

- Vision discount program through Davis Vision
- Medical travel assistance through Assist America
- 24-hour nurse line

OHIO STATE SPECIFIC BENEFIT EXCLUSIONS

Skilled Nursing Facility

Exclusions under this benefit include:

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

Prescription Drugs

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

- 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 this certificate.
- 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.
- Off label use, except as otherwise prohibited by law.
- Drugs in quantities exceeding the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription Order.
- Drugs not approved by the FDA.
- Charges for the administration of any Drug.
- 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.
- Any Drug which is primarily for weight loss.
- 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.
- Drugs for treatment of sexual or erectile dysfunctions or inadequacies, regardless of origin or cause.
- Fertility Drugs, unless covered elsewhere in this certificate.
- 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.
- Drugs in quantities which exceed the limits established by the Plan.
- Compound Drugs unless there is at least one ingredient that requires a prescription.
- Treatment of Onchomycosis (toenail fungus).
- Certain Prescription Legend Drugs are not Covered Services when any version or strength becomes available over the counter except for Preventive Services.
- Brand-Name Prescription Drugs with generic equivalents.

Orthotic Devices

Exclusions

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

Accidental Injury Dental Treatment for Insured Persons

Exclusions under this benefit:

- orthodontic braces and orthodontic appliances.
- 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.

EXCLUSIONS

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 this 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 this 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 this 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 this 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 this 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 this 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 this 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 this 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 this Certificate.
35. For care received in an emergency room which is not Emergency Care, except as specified in this 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 this 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, bioenergetic 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 this 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 this Certificate, or as required by law.
52. Nutritional and/or dietary supplements, except as provided in this 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 this 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 this 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