UNIVERSITY OF WISCONSIN-MADISON
STUDENT HEALTH INSURANCE PLAN
INTERNATIONAL

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HEALTH CARE EXPENSE PLAN

1. **Establishment and Permanency of this Plan**: The University of Wisconsin-Madison (hereinafter called the University) hereby establishes the University of Wisconsin-Madison Student Health Insurance Plan (hereinafter called this Plan) effective as of August 15, 2022. The Plan has been approved by the Centers for Medicare & Medicaid Services (CMS) as Minimum Essential Coverage (MEC) effective 8/15/15. Legally required benefits not herein fully described are automatically adopted by reference.

2. **University's Right to Amend**: The University reserves the right to:
   a. Amend this Plan at any time, and from time-to-time and retroactively, if deemed necessary or appropriate or if necessary to meet the requirements of State and Federal law;
   b. Modify or amend, in whole or in part, any or all of the provisions of this Plan, and the Participants and their beneficiaries under this Plan covenant to said changes which may increase or decrease coverage or change the rules of this Plan; and
   c. Determine claim payments, notwithstanding the delegation of these and other administrative responsibilities of this Plan, provided however, that no such modification or amendment will make it possible for any funds committed to this Plan to be used for, or diverted to, purposes other than for the exclusive benefit of Participants and their beneficiaries under this Plan; all by a written resolution by a named fiduciary of the University.

3. **Purpose of this Plan**: This Plan provides benefits to Covered Students of the University, who are participants hereunder, which benefits reimburse participants for expenses incurred for the health care of themselves, their legal spouses or domestic partners, and their legal children as the result of non-occupational Accidental bodily injuries and Illnesses to the extent herein provided.

4. **Premiums and Funding**: Participants are required to pay premium to maintain coverage under this Plan. This Plan will document required premium in writing upon request.

5. **Termination of this Plan**: The University reserves the right to discontinue or terminate this Plan at any time without prejudice.

SUMMARY PLAN DESCRIPTION

The information furnished herein is designed to acquaint the Covered Person with the benefits of the Plan that are now available to the Covered Student and Covered Dependents.

General Information

Plan Sponsor (University):	University of Wisconsin-Madison Madison, WI 53706
Plan Name:	University of Wisconsin-Madison Student Health Insurance Plan
Plan Administrator:	University of Wisconsin-Madison
University Locations Covered by this Plan (if any):	All locations are covered unless otherwise excluded by this Plan
Third Party Administrator:	Wellfleet Group, LLC P.O.Box 15369 Springfield, MA 01115
Address of this Plan:	**UW-Madison Student Health Insurance Plan** **University Health Services** 333 East Campus Mall-7th Floor # 7104 Madison, WI 53715-1381 Phone: (608)265-5232 Fax: (608)265-5668 Email: shipmail@uhs.wisc.edu **SHIP Office Regular Hours:** Monday through Friday: 9am to 5pm
Plan Number:	501
Plan Effective Date:	August 15, 2022
Plan Year:	August 15th through August 14th

DEFINITIONS

The following words and phrases, if used in this Plan, will have the following meanings. Any services, treatment or supplies not specifically listed in this Plan Document as Eligible Expenses are not covered by this Plan.

Accident refers to an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Illness or disease of any kind; and (c) causes Injury.

Activities of Daily Living are the day-to-day activities, such as continence, dressing, feeding, toileting and transferring.

Administrator or **Plan Administrator** means the fiduciary named in this Plan.

Alcoholism is the condition caused by regular excessive compulsive drinking of alcohol that results in a chronic disorder affecting physical health and/or personal or social functioning.

Ambulance is a specially designed vehicle transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment and other life saving equipment required by the state and local law and that is staffed by personnel trained to provide first aid treatment.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by Registered Nurses (R.N.'s) and does not provide for overnight stays.

Amendment is the formal process and resulting document that changes the provisions of the Plan Document, duly signed by the authorized person(s) as designated by the Plan Administrator.

Area means a county or larger geographic area, if a larger area is required, needed to obtain a representative level of Usual, Customary and Reasonable (UCR) charges.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means a facility licensed in the state where operating which is equipped and operating solely to provide prenatal and post-partum care in connection with spontaneous deliveries, which includes:

1. The direction by at least one Physician specializing in obstetrics and gynecology,
2. The presence of a Physician or nurse midwife during each birth and immediate post-partum period,
3. The presence of full-time skilled nursing services in the delivery rooms and recovery rooms under the direction of a Registered Nurse (R.N.) or nurse midwife,
4. The extension of staff privileges to Physicians who provide obstetrical and gynecological care in an area hospital,
5. At least two beds or birthing rooms for patients during labor and delivery,
6. Diagnostic x-ray, testing and laboratory equipment (or a contract to use such equipment at an area hospital),

Birthing Center, (continued)

7. Equipment and supplies for administration of local anesthetic for performing minor surgical procedures and medical emergencies (including oxygen and resuscitation equipment, intravenous fluids and drugs to control the mother's bleeding and drugs to assist the newborn's breathing),

and which regularly charges patients for services and supplies, admits only patients with low risk pregnancies, contracts with an area hospital and displays written procedures for the immediate transfer of mother and child in emergency cases and has an ongoing quality assurance program (with reviews by Physicians other than those who own and/or direct the facility).

Certified Registered Nurse Anesthetist (C.R.N.A.) is a Registered Nurse certified to administer anesthesia, who is employed by and under the personal supervision of a Physician Anesthesiologist.

Chemical Dependency means Drug Abuse, Substance Abuse or Alcoholism.

Coinsurance means the percentage of charges that the Covered Person is required to pay for eligible charges/expenses under this Plan.

Confined, when used in connection with a hospital, means a period of twenty-four (24) hour days, but no less than one such day, during which the Covered Person is confined in a facility for which there is a daily charge made for room and board.

Continuously Covered means a person has been continuously covered under this Plan.

Copayment or **Copay** means that amount of Eligible Expense, which the Covered Person is required to pay before benefits may begin by this Plan.

Cosmetic, Cosmetic Dentistry, Cosmetic Surgery and Cosmetic Procedures means medically unnecessary surgery or other medical procedures, usually, but not limited to, plastic surgery which is intended to improve appearance but does not improve function of a body part.

Covered Dependent means an eligible Dependent the Covered Student has elected to include in this Plan and for whom the Covered Student has submitted any applicable premium required by this Plan by the due date.

Covered Person means either the Covered Student or the Covered Dependent while coverage is in force, but in no case can a Covered Person be considered both a Covered Student and a Covered Dependent under this Plan.

Covered Student means an eligible international student, or J-1 scholar, who has elected to participate in this Plan and submitted any applicable premium as required by this Plan by the due date.

DEFINITIONS

Custodial Care means any service or supply, including room and board, which is furnished mainly to help a person meet his or her routine daily needs. Even if the Covered Person is in a hospital or other recognized facility, this Plan does not pay for care if it is mainly custodial unless specifically provided for in the schedule of benefits.

Deductible means that amount of Eligible Expense that the Covered Person is required to pay before benefits are payable under this Plan.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent means any of the following:

1. The lawful spouse of the Covered Student for whom the Covered Student is legally responsible, and who is not also a Covered Student, resides with the Covered Student and is not legally separated or divorced from the Covered Student.
2. The Covered Student's same sex or opposite sex domestic partner provided they are living together and a written declaration of domestic partnership acceptable to this Plan has been completed and/or any applicable requirements of the state, city and/or country in which they reside regarding domestic partnership have been met.
3. Any child or stepchild of the Covered Student less than twenty-six (26) years of age.
4. Any unmarried child or stepchild who is at least twenty-six (26) years of age, but under the age of twenty-seven (27) provided the child is attending an accredited institution of higher learning on a full-time basis as defined by the school, is living in the same country as the Covered Student (with the exception of eligible full-time students temporarily studying abroad), and is financially dependent upon the Covered Student for the major part of support.
5. The Covered Student's domestic partner's child under the age of 26, or unmarried age 26 but under age 27.
6. Any unmarried child or stepchild who is mentally or physically disabled and incapable of earning a living and entirely dependent upon the Covered Student for support. This Plan will have the right to require documentation of the disability, but not more often than once every year.
7. Any unmarried child or stepchild of the Covered Student who is at least twenty-six (26) years of age, but under the age of twenty-seven (27) provided the child or stepchild is not eligible for coverage under a group health benefit plan that is offered by his or her employer and for which the amount of his or her premium contribution is no greater than the premium amount for his or her coverage as a dependent under this Plan.
8. An adult child or stepchild of the Covered Student or Covered Student's domestic partner regardless of age if the child was under 27 years of age when he or she was called to federal active duty in the National Guard or in a reserve component of the U.S. armed forces while the child was attending, on a full-time basis, an institution of higher education and the child returns to school as a full-time student within 12 months of fulfilling his or her active duty obligation.

DEFINITIONS

Drug Abuse is physical, habitual dependence on drugs. This includes, but is not limited to, dependence on drugs that are medically prescribed. This does not include tobacco or caffeine abuse or dependence which Treatment is excluded by this Plan.

Durable Medical/Surgical Equipment and Supplies are:
1. Primarily and customarily used for medical purposes and are not generally useful in the absence of an Illness or Injury,
2. Can effectively be used in a non-medical facility (home),
3. Are expected to make a significant contribution to the Treatment of an Illness or Injury,
4. Are used solely for the care and Treatment of the patient, and
5. Are priced so that the cost of the equipment/supplies is proportionate to the therapeutic benefits that can be derived from the use of the equipment/supplies.

Elective Surgical Procedure is a non-emergency surgical procedure, which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Eligible Expense means a charge for Treatment not excluded by this Plan resulting from Treatment of an Accident or Illness that must be:
1. Consistent with the diagnosis and treatment of the Covered Person's condition,
2. In accordance with standards of good medical practice,
3. Not solely for the convenience of the patient, Physician or supplier,
4. Neither Experimental nor Investigational,
5. Performed in the least costly setting required by the patient's medical condition. The act of prescribing a course of Treatment does not automatically mean that Treatment will result in an Eligible Expense,
6. Within this Plan's description of Usual, Customary and Reasonable (UCR) expenses,
7. Incurred within a period of time during which the claimant was a Covered Person.

Emergency Services means, with respect to a Medical Emergency:
(a) a medical screening examination (as required under section 1867 of the Social Security Act, 42, U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency; and
(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency Services treatment or care rendered by an Out-of-Network provider is mandated by the Patient Protection and Affordable Care Act to be provided at the same benefit and cost sharing level as services provided by a Network provider.

Experimental and/or Investigational means services, supplies, care and Treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

Experimental and/or Investigational (continued)
In determining coverage under this Plan, the Plan Administrator and the Third Party Administrator shall make an independent evaluation of the experimental status of specific technologies and shall be guided by a reasonable interpretation of Plan provisions. The decision(s) shall be made in good faith and will be rendered following a detailed factual background investigation of the claim and the proposed treatment. In making such a determination, the Plan Administrator and the Third Party Administrator will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function or if Federal law requires such review or approval; or
3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental, study or investigational arm or ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy or it's efficacy as compared with a standard means of treatment or diagnosis; or
4. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy or it's efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

The decisions of the Plan Administrator and the Third Party Administrator will be final and binding on this Plan.

Generic Drug means a prescription drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed Pharmacist and clearly designated by the Pharmacist as being generic.

Home Health Care means part-time or intermittent nursing care, including the Medically Necessary supplies for Treatment of the Covered Illness or Injury. Home health care must be in place of Hospital confinement.

DEFINITIONS

Hospice means a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent hospice administration and it helps the patient cope with physical, psychological, spiritual, social and economic stresses. The hospice administration must meet the standards of the National Hospice Organization and any licensing requirement.

Hospital means an institution which:

1. Maintains permanent and full-time facilities for bed care of resident patients,
2. Has a licensed Physician in regular full-time attendance,
3. Continuously provides 24 hour-a-day nursing service by Registered Nurses,
4. Has on-premises surgical facilities,
5. Is primarily engaged in providing diagnostic, surgical, medical and therapeutic facilities for the care of injured and sick persons on a basis **other than** as a rest home, nursing home, convalescent home, a place for custodial or educational care, a place for the aged, a place for substance abusers or as an institution mainly rendering treatment or services for mental or nervous disorders, and
6. Is licensed and operating lawfully in the jurisdiction where it is located.
7. This does not include a Government Facility.

Illness means disease or sickness including related conditions and recurrent symptoms of the Illness. Illness also includes pregnancy and complications of pregnancy.

Injury means bodily injury caused by an Accident. This includes related conditions and recurrent symptoms of such injury.

In-Network describes a provider or health care facility which is part of a health plan's network of providers. Providers are contracted with the network entity to provide lower health care expenses to the Plan and the member.

Intensive Care Unit means Hospital special twenty-four (24) hour nursing care and equipment in a room other than a Ward, Semi-Private, or Private room, which services are made necessary by the Covered Person's critical medical condition and which provides other than normal, routine treatment.

International Student means any student registered for class(es) at the University with any type of non-immigrant status actively being used for the current semester in the U.S.

J-1 Scholar means a visiting scientist, professor, post doctoral fellow, student in academic training who has completed their program of study, or non-degree research project student at the University on a J-1 visa and not registered for any University class(es). SHIP is not available to scholars on any other type of visa.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

DEFINITIONS

Medical Emergency means a sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could result in serious jeopardy to the participant's health or bodily functions, or with respect to a pregnancy, could result in serious jeopardy to the health of the woman or her unborn child. In addition, Medical Emergency includes a mental health or chemical dependency condition when the lack of medical treatment could reasonably be expected to result in the Covered Person harming oneself and/or other persons.

Medically Necessary means any health care treatment, service or supply determined by the Plan Administrator to meet each of these requirements:

1. It is ordered by a Physician for the diagnosis or treatment of a ***covered*** Illness or Injury;
2. The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use, and that omission would adversely affect the person's medical condition; and
3. It is furnished by a provider with appropriate training, experience, staff and facilities to furnish that particular service or supply.

The Plan Administrator and the Third Party Administrator will determine whether these requirements have been met based on: 1) published reports in authoritative medical and scientific literature; 2) regulations, reports, publications or evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institute of Health, and the Food and Drug Administration's (FDA); 3) listings in the following compendia: The American Medication Association Drug Evaluations, the American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information; and 4) other authoritative medical sources to the extent that the Third Party Administrator determines them to be necessary.

Mental Health Conditions means a condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental Health Conditions include mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions, behavioral conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

Morbid Obesity is defined as when a person's body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight for a person of the same gender, height, age and mobility.

Newborn Dependent means any child for whom birth occurred while the student was a Covered Person under this Plan.

Non-Occupational Disease or Injury means an Illness or Injury which does not arise out of, and which is not caused or contributed by, nor is a consequence of, or in the course of, any employment or occupation for compensation and profit.

DEFINITIONS

Out-of-Network describes a provider or health care facility which is not part of a health plan's network of providers. Members may pay more when using an out-of-network provider since there is no contracted amount for health care expenses.

Out-of-Pocket Expenses means that portion of Eligible Expenses for which the Covered Person is responsible as the result of Coinsurance, Copayments and Deductible.

Partial Hospitalization refers to services, supplies and Treatment in an approved facility for not less than four (4) hours or more than sixteen (16) hours in any twenty-four (24) hour period.

Participating Provider or Network Provider is a provider, such as a Physician, Hospital, or other health facility or provider who is under a contractual agreement with this Plan to provide care or services to Covered Persons.

Payable Expense is the balance of Eligible Expenses remaining after the application of deductibles, coinsurance, copayments, discounts and that is submitted to this Plan for payment within the Timely Filing period.

Physician means a person, other than a member of the Covered Person's immediate family, a blood relative, or a person who normally lives in the Covered Person's home and who:

1. Has a designation of either M.D., D.O., D.P.M., or
2. A provider acting within the scope of the license provided by the state in which the Physician practices.

Plan means this entire document.

Plan Year means the entire Plan Year beginning on August 15th through August 14th.

Preventive Care means routine examinations, physicals, gynecological exam, immunizations, routine urinalysis and other routine screening tests.

Preventive Services mandated by the Patient Protection and Affordable Care Act and, in addition to any other preventive benefits described in this Plan, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;

Preventive Services (continued)

3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

This Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Primary Care is the first care a patient receives for a covered Illness or Injury.

Provider of Services means a Physician or any legally recognized supplier of medical services or supplies operating at the direction of the Covered Person's Attending Physician which services or supplies can be described as Eligible Expenses.

Psychologist means a person, other than a member of the Covered Person's immediate family, with a degree of Ph.D. or Ed.D. operating at the direction of the Covered Person's Attending Physician which services or supplies can be described as Eligible Expenses.

Registered Nurse means a professional nurse, other than a member of the Covered Person's immediate family, enabled to use the title Registered Nurse and its designation R.N., performing the duties and acting within the scope of the license provided by the state in which practicing.

Rehabilitation Facility, Extended Care Facility, Skilled Nursing Facility, Convalescent Care Facility, and **Residential Center** all mean an institution, other than a Hospital, licensed by the state where located, which exists for the purpose of active rehabilitation of patients during a Period of Confinement and which:

1. Provides skilled nursing care under twenty-four (24) hour a day supervision of an Active, Full-Time Physician or Registered Nurse,
2. Has available at all times the services of a Physician who is a Hospital staff member,
3. Maintains a daily record for each patient, and
4. Is not a place, except incidentally, for
   a. Rest,
   b. Custodial Care,
   c. The aged,
   d. The care of drug addicts nor alcoholics, and
5. Is not a hotel, domiciliary care neither home, nor similar institution, and
6. Is licensed and operating lawfully in the jurisdiction where it is located.

Second Surgical Opinion means another opinion on an anticipated surgical procedure which opinion is rendered by a Surgeon who is not:

1. The Physician who originally recommended the surgery;
2. A partner in practice with the Physician who originally recommended the surgery;
3. The Physician who actually performs the procedure in question.

DEFINITIONS

Semi-Private means a two-bed room accommodation.

Sound Natural Teeth means natural teeth, the major portion of the individual tooth, which is present regardless of fillings and is not carious, abscessed, or defective. Sound natural teeth shall not include capped teeth.

Speech Therapist, Physical Therapist, Occupational Therapist, Respiratory Therapist means a licensed person or institution providing therapy, or, if licensing is not required, the therapist is certified by his or her national organization or association.

Substance Abuse or **Chemical Dependency**, see Alcoholism and Drug Abuse.

Surgical Center, see Ambulatory Surgical Center.

Temporomandibular Joint Syndrome (TMJ) is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Treatment means any contact with any provider of health care involving the condition in question or the taking of any medicine prescribed for the condition in question.

University means University of Wisconsin-Madison.

University Health Services means any organization, facility or clinic operated, maintained or supported by the University or other entity under contract with the University which provides health care services to Covered Persons.

Urgent Care means care for an unexpected Illness or Injury which does not require use of a Hospital's Emergency Room, but which may need prompt attention, and include, but are not limited to: cold, sore throat, cough, fever, vomiting, sprain or strain, cramps, diarrhea, bumps and bruises, small lacerations, minor burns, earache, rashes, swollen glands, conjunctivitis.

Usual, Customary and Reasonable (UCR), when used in connection with a fee for Treatment, means the lesser of:

1. the actual charge, or
2. usual & customary charges as determined by FAIR Health, Inc.

but never more than the provider of Treatment accepts from any other source of payment of charges for the same treatment.

You, Your means the Covered Student.

PRIMARY CARE PROVIDER

Covered Students and Covered Spouses/Partners are required to use **University Health Services (UHS) Clinical Services and Counseling and Consultation Services** for all available eligible preventive care.*

Health care rendered by UHS is covered in full without application of any deductible or coinsurance for all Eligible Expenses.

Location:

UHS Medical Services
333 East Campus Mall, 5th and 6th Floors, Madison
Primary Care Clinic; Women's Clinic; STI Testing and Treatment; Allergy/ Immunization Clinic; Travel Clinic; Sports Medicine Clinic

UHS Counseling & Consultation Services
333 East Campus Mall, 7th Floor, Madison
Crisis Intervention; Individual and Group Counseling; Relationship Counseling; Alcohol, Tobacco and Other Drug Abuse

Appointments and General Information:
(608) 265-5600
TTY number: 265-3300
UHS Regular Hours:
Mon | Tue | Thu | Fri: 8:30am to 5pm
Wed: 9am to 5pm

***Waiver of Primary Preventive Care Provider Requirements**
This Plan will not reimburse any Preventive Care not obtained from UHS unless:

1. Eligible Preventive Care is not available through UHS or cannot be rendered at UHS.
2. A Covered Student or Covered Spouse/Domestic Partner is on a University approved rotation or course outside the Madison area.
3. A Covered Student or Covered Spouse/Domestic Partner is a medical student who opts not to receive medical care from UHS.

In the case of 1., 2., and 3. above, Eligible Expenses will be considered according to the Schedule of Benefits and will be subject to any deductible and/or coinsurance. Covered Dependent Children are not eligible to utilize UHS services, thus all incurred expenses are considered based upon the Schedule of Benefits.

Per Patient Protection and Affordable Care Act, if designation of a primary care Physician is required, the Covered Person must be allowed to designate a Physician who specializes in pediatrics as the child's primary care Physician if the provider is in the network. No Primary Care Provider Requirements shall apply to obstetrical or gynecological care provided by Network providers.

IN-NETWORK PREFERRED PROVIDERS

In order to provide this Plan with a comprehensive and flexible network arrangement when appropriate health care at the University Health Services cannot be obtained, The Alliance network will be utilized. In addition to an extensive network of participating providers in Madison, The Alliance service area extends from the Upper Michigan Peninsula border (north) to Northern Illinois (south) and from Waukesha (east) to Dubuque (west). The Alliance is a recognized network of hospitals, ancillary service providers and physicians. The Covered Person may locate participating providers either by contacting The Alliance or by using the provider links at: www.uhs.wisc.edu/ship

The Alliance
5510 Nobel Drive
Fitchburg, WI
(800) 223-4139

In the event there no providers in The Alliance network, the Covered Person also has access to the First Health network.

First Health, A Coventry Healthcare company
(800) 226-5116

Discounts obtained through prompt-payment negotiation do not result in the payment of any such claims as In-Network, however, if the Plan has Out-of-Network benefits, the discount will be "shared" with the Claimant by reducing the total cost of the incurred charge with a resultant decrease in the Covered Person's cost-share.

Medical Emergencies
Covered participants should identify which hospitals and urgent care centers are network participants so that they will know where to go in an emergency or urgent situation. In the event of a **life threatening medical emergency**, go to the closest hospital's emergency room.

Availability of Providers
The Alliance or First Health network cannot guarantee the availability or continued participation of a particular provider. The Alliance or First Health network or the providers may terminate the provider contract or limit the number of patients it is currently accepting. ***The provider's continuing status as a network participant should be confirmed with the network provider prior to utilizing any provider of service.***

Hospital Ancillary Services
This Plan will consider Out-of-Network ancillary physician services - such as those provided by radiologists, pathologists, emergency room physicians, and anesthesiologists - at the In-Network benefit rate subject to Usual, Customary and Reasonable (UCR) provided that services were rendered while the Covered Person was an inpatient or outpatient at an In-Network Hospital or Ambulatory Surgery Center. Services rendered by any Out-of-Network ancillary physician after discharge from the Network facility or surgery center will be considered at the Out-of-Network benefit rate limited to UCR Allowances. Different benefits may apply for non-emergency use of a hospital's emergency room or for medical emergency use of an Out-of-Network emergency room. Refer to the appropriate medical schedule of benefits for more information. Services rendered while inpatient or outpatient at an In-Network Hospital or Surgery Center by any Out-of-Network Physician or medical practice for which the Covered Person is an established patient will be considered at the Out-of-Network benefit rate limited to UCR Allowance (if Out-of-Network benefits are applicable).

IN-NETWORK PREFERRED PROVIDERS

The Alliance QualityPath Program

About the Program

Definition – The *QualityPath* Program is designed to provide incentives for patients to choose *QualityPath* providers for select services. The purpose of this program is to encourage patients to choose health care providers who have met rigorous quality standards. Only those health care providers who have met the *QualityPath* standards have been selected to participate in *QualityPath*.

Covered Providers/Services – *QualityPath* provides enhanced benefits if you select a designated provider for a *QualityPath* designated procedure. The listing of *QualityPath* designated procedures, providers and services is available on The Alliance website at www.qualitypath.com or by calling 800.223.4139.

Benefit coverage limits and cost-sharing – *QualityPath*-eligible services will be covered at 100% with no member out-of-pocket costs for care. For a listing of *QualityPath*-eligible services, go to The Alliance website at www.qualitypath.com or call The Alliance Customer Service department at 800.223.4139.

Member Responsibilities

Members must receive the service from a designated *QualityPath* provider. The listing of eligible physicians and facilities is available on The Alliance website at www.qualitypath.com.

Members must follow any post-service instructions provided by the facility and/or physician including any post-operative therapy or cardiac rehab if applicable.

Contact The Alliance at 800.223.4139 if you are unable to access any of this information online.

Warranty Period

The *QualityPath* program includes a warranty period in which all care for complications related to the *QualityPath* service is provided at no additional charge to the member. Warranty details are available on The Alliance website at www.qualitypath.com or by calling 800.223.4139.

Requirements during the warranty period include:

- Follow-up care related to the *QualityPath* service is to be provided by the *QualityPath* provider except for necessary emergency care.
- Members must comply with post-service instructions including outpatient rehabilitation or physical therapy if applicable to be eligible for the warranty.

ELIGIBILITY AND COMPLIANCE

All International Students, J-1 Scholars and visa dependents are required to have University of Wisconsin – Madison approved health insurance coverage. International students and J-1 Scholars must purchase SHIP for themselves and any visa dependents or file a qualifying waiver by the posted deadlines.

Ineligible Categories:

- Classes taken as a guest student
- Auditing classes
- Classes taken exclusively at an academic institution other than the University
- Classes taken exclusively online from outside the U.S.

Eligibility Requirements

The SHIP office maintains the right to investigate eligibility status to verify that the SHIP eligibility requirements have been met. If the SHIP office discovers that the SHIP eligibility requirements have not been met, the SHIP office's only obligation is a full premium refund, minus the cost of any claim benefits paid by the Plan.

Compliance Deadlines for International Students

The SHIP office must receive a completed enrollment application and full payment or a qualifying waiver, on or before the posted deadlines. For International Students who enroll after their effective date, SHIP coverage will be retroactive from the effective date of the applicable enrollment period.

Annual and Fall Compliance Deadline: September 14

- Open enrollment is July 15-September 14
- Annual SHIP coverage is effective August 15 and terminates August 14
- Fall SHIP coverage is effective August 15 and terminates January 14

Spring/Summer Compliance Deadline: February 14

- Open enrollment is December 15-February 14
- Spring/Summer SHIP coverage is effective January 15 and terminates August 14

Summer Compliance Deadline (Newly eligible students only): Within 31 days of the first day of class

- Summer SHIP coverage is effective from the first day of class and terminates on August 14.

Failure to Comply - International Students

International students who fail to purchase SHIP or file a qualifying waiver by the compliance deadline will be automatically enrolled in SHIP.

International students who make payment after the compliance deadline will be charged a $100 late fee and required to pay SHIP premiums from the beginning of the initial compliance period.

International students who file a qualifying waiver after the compliance deadline will be charged a $100 late fee in addition to any required premiums.

ELIGIBILITY AND COMPLIANCE

International Students who fail to meet the compliance deadline will be considered non-compliant with the health insurance requirements of UW-Madison and an academic hold will be placed on the International Student's academic record. An academic hold prevents International Students from adding classes, dropping classes, or obtaining a copy of their transcripts or diploma.

An academic hold will not be removed until the International Student is compliant. Outstanding balances must be made by VISA/MasterCard/Discover or exact cash. If the outstanding balance remains unpaid, the account will be referred to a collections agency.

Compliance Deadlines for J-1 Scholars
The SHIP office must receive a completed enrollment application and full payment, or a qualifying waiver, on or before the posted deadlines. For J-1 Scholars who enroll after their effective date, SHIP coverage will be retroactive from the effective date of the applicable enrollment period.

Newly Arrived J-1 Scholars
Within 31 days of the later of the DS-2019 start date, arrival date, or visa transfer date

- SHIP coverage is effective from the later of the DS-2019 start date, arrival date, or visa transfer date.

J-1 Scholars with a DS-2019 Extension
Within 31 days of the waiver/SHIP coverage end date

- SHIP coverage is effective from the beginning of the 31 day compliance period.

Renewing J-1 Scholars
Within 31 days of the waiver/SHIP coverage end date

- SHIP coverage is effective from the beginning of the 31 day compliance period.

SHIP Premiums are payable on an Annual (12 months) or Half Yearly (6 months) basis

- Annual SHIP coverage is effective August 15 and terminates August 14
- First Half Yearly SHIP coverage is effective August 15 and terminates February 14
- Second Half Yearly SHIP coverage is effective February 15 and terminates August 14
- *Note:* J-1 Scholars who arrive during the First Half Yearly period have the option to pay a partial premium through the end of that period – February 14, or through August 14.
- Premiums are pro-rated for J-1 Scholars who are in the United States for a shorter period (subject to a one month minimum requirement).

Important! - SHIP coverage is comprised of 12 billing cycles that run from the 15th of a month through the 14th of the next month.

ELIGIBILITY AND COMPLIANCE

- At the beginning of their SHIP enrollment J-1 Scholars are required to pay for the monthly billing cycle in which the later of their DS-2019 start date, arrival date, or visa transfer date falls.
- At the end of a J-1 Scholar's SHIP enrollment, coverage will terminate on the 14th of the month following the DS-2019 end date or verifiable departure date.

Please refer to the table below for specific examples of how the start and end date of your compliance period can affect your SHIP premium.

Insurance Compliance Start (The later of your DS-2019 start date, arrival date, or visa transfer date)	**Insurance Compliance End (The earlier of your DS-2019 end date or verifiable departure date)**	**SHIP Billing Cycle (The total number of monthly premiums that you will be required to pay)**			**SHIP Coverage (The actual period of your SHIP coverage)**	
		From	**To**	**Months**	**Starts**	**Ends**
10/16/2022	11/06/2023	10/15	11/14	1	10/16	11/14
10/14/2022	11/15/2023	9/15	12/14	3	10/14	12/14
9/12/2022	01/17/2023	8/15	2/14	6	9/12	2/14
9/12/2022	8/12/2023	8/15	8/14	12	9/12	8/14

Failure to Comply - J-1 Scholars

J-1 Scholars who fail to purchase SHIP or file a qualifying waiver by the compliance deadline may be automatically enrolled in SHIP.

J-1 Scholars who make payment after the compliance deadline will be charged a $100 late fee and required to pay SHIP premiums from the beginning of the initial compliance period.

J-1 Scholars who file a qualifying waiver after the compliance deadline will be charged a $100 late fee in addition to any required premiums.

J-1 Scholars who fail to meet the compliance deadline will be considered non-compliant with the health insurance requirements of UW-Madison. Failure to maintain compliance with the UW-Madison insurance requirement can jeopardize the J-1 program status of a J-1 Scholar. Visa requests (such as visa extensions or travel visas) may also be denied by the International Faculty Staff Services office until health insurance compliance is achieved.

Outstanding balances must be paid by VISA/MasterCard/Discover or exact cash. If the outstanding balance remains unpaid, the account will be referred to a collections agency.

ELIGIBILITY AND COMPLIANCE

Dependent Eligibility

Covered Students can also enroll a Dependent or Dependents in SHIP if they are not visa dependents. The Covered Student must register any such Dependents at the same time the Covered Student enrolls. If the Covered Student does not enroll the Dependent or Dependents in SHIP by the enrollment deadline, the Covered Student must wait until their next enrollment period, unless there is a Qualifying Event. If the Dependent is a domestic partner, both partners must sign a notarized affidavit of their domestic partnership before enrollment.

A newborn child and adopted child shall be covered for Illness and Injury, premature birth and medically diagnosed congenital defects and birth abnormalities from the moment of birth or adoption for an initial period of sixty (60) days. To continue coverage beyond this initial sixty (60) day period, the Covered Student must notify this Plan of the birth or adoption and pay any additional premium required in accordance with the Qualifying Event conditions.

QUALIFYING EVENTS

If the qualifying conditions are met, SHIP coverage will be effective from the date of the Qualifying Event and the cost of coverage will be pro-rated for the remainder of the enrollment period (subject to a one month minimum requirement)

Important! - SHIP coverage is comprised of 12 billing cycles that run from the 15th of a month through the 14th of the next month.

Qualifying Events include:

- **Birth of a child**. You can add a newborn child within 31 days of the birth of the child. If the 31-day deadline is missed You must wait until the next enrollment period to enroll Your child.

- **Adoption of children**. You can add an adopted child within 31days of the date of the adoption by providing a copy of the legal documentation. If the 31-day deadline is missed You must wait until the next enrollment period to enroll Your child.

- **Marriage**. You can add a spouse within 31 days of the marriage by providing a copy of the marriage license. If the 31-day deadline is missed You must wait until the next enrollment period to enroll Your spouse.

- **Newly formed domestic partnership**. You can add a domestic partner to Your SHIP policy if the domestic partnership was formed within the last 31 days. Both partners must sign a notarized affidavit of their domestic partnership before enrollment. If the 31-day deadline is missed You must wait until the next enrollment period to enroll Your domestic partner.

- **Arrival of visa dependents into the United States**. You are required to enroll any visa dependents in SHIP within 31 days of their arrival into the United States by presenting copies of the relevant passport(s). If You fail to enroll Your visa dependents in SHIP within 31 days, a $100 late fee will be applied in addition to any required premiums.

- **Loss of insurance for waived International students, J-1 scholars and any visa dependents**. If the qualifying insurance coverage ends during the waived period, You are required to enroll yourself and any visa dependents in SHIP or file another qualifying waiver within 31 days of the date of loss. If You and any visa dependents do not qualify for another waiver and You fail to enroll yourself and any visa dependents in SHIP within 31 days, a $100 late fee will be applied in addition to any required premiums.

TERMINATIONS AND REFUNDS

SHIP premium refunds cannot be backdated. The SHIP office can only process premium refunds in the following instances: (Please note that refunds can take up to eight weeks to be processed and can only be sent to a U.S. address)

International Students who no longer meet the SHIP eligibility requirements
You will be contacted when the SHIP office receives notification that You no longer meet the SHIP eligibility requirements.

International Students who no longer meet the SHIP eligibility requirements for fall
If You no longer meet the SHIP eligibility requirements for non-medical reasons on September 14 for fall, You shall not be covered by the Plan**. A full premium refund will be processed, minus the cost of any claim benefits paid by the Plan.**

If You no longer meet the SHIP eligibility requirements for non-medical reasons on or after September 15 for fall, Your SHIP coverage will be terminated from the 15th of the month following the date You are no longer eligible, and a pro-rated premium refund will be processed.

If You no longer meet the SHIP eligibility requirements for medical reasons for fall, You will be allowed to remain on SHIP through January 14 (subject to verification). You will also be required to pay the fall University Health Services fee to continue Your SHIP coverage.

If You no longer meet the SHIP eligibility requirements for medical reasons on September 14 for fall and You were previously approved to remain on SHIP for medical reasons through the preceding August 14, You shall not be covered by the Plan**. A full premium refund will be processed, minus the cost of any claim benefits paid by the Plan.**

If You no longer meet the SHIP eligibility requirements for medical reasons on or after September 15 for fall and You were previously approved to remain on SHIP for medical reasons through the preceding August 14, Your SHIP coverage will be terminated from the 15th of the month following the date You are no longer eligible, and a pro-rated premium refund will be processed.

International Students who no longer meet the SHIP eligibility requirements for spring/summer
If You no longer meet the SHIP eligibility requirements for non-medical reasons on February 14 for spring/summer, You shall not be covered by the Plan. **A full premium refund will be processed, minus the cost of any claim benefits paid by the Plan.**

If You no longer meet the SHIP eligibility requirements for non-medical reasons on or after February 15 for spring/summer, Your SHIP coverage will be terminated from the 15th of the month following the date You are no longer eligible, and a pro-rated premium refund will be processed.
Note – for spring/summer You need to meet the SHIP eligibility requirements through the spring semester only.

If You no longer meet the SHIP eligibility requirements for medical reasons for spring/summer, You will be allowed to remain on SHIP through August 14 (subject to verification). You will also be required to pay the spring University Health Services fee to continue Your SHIP coverage.

TERMINATIONS AND REFUNDS

If You no longer meet the SHIP eligibility requirements for medical reasons on February 14 for spring/summer and You were previously approved to remain on SHIP for medical reasons through the preceding January 14, You shall not be covered by the Plan**. A full premium refund will be processed, minus the cost of any claim benefits paid by the Plan.**

If You no longer meet the SHIP eligibility requirements for medical reasons on or after February 15 for spring/summer and You were previously approved to remain on SHIP for medical reasons through the preceding January 14, Your SHIP coverage will be terminated from the 15th of the month following the date You are no longer eligible, and a pro-rated premium refund will be processed.

International students who enroll for annual coverage, but do not meet the SHIP eligibility requirements for the spring/summer semester as of January 15th, will be automatically refunded for the spring/summer semester coverage period.

International Students who no longer meet the SHIP eligibility requirements for summer
If You no longer meet the SHIP eligibility requirements for non-medical reasons 31 days from Your first day of summer class for summer (newly eligible summer students only), You shall not be covered by the Plan. **A full premium refund will be processed, minus the cost of any claim benefits paid by the Plan.**

If You no longer meet the SHIP eligibility requirements for non-medical reasons on or after 32 days from Your first day of summer class for summer (newly eligible summer students only), Your SHIP coverage will be terminated from the 15th of the month following the date You are no longer eligible, and a pro-rated premium refund will be processed.

If You no longer meet the SHIP eligibility requirements for medical reasons for summer (newly eligible summer students only), You will be allowed to remain on SHIP through August 14 (subject to verification).

If You no longer meet the SHIP eligibility requirements and do not receive any communication from the SHIP office, You must contact the SHIP office if You want to apply for a premium refund.

SHIP International Students, or J-1 scholars who file a qualifying waiver
If the SHIP office receives Your completed Waiver Application prior to the effective date of Your qualifying insurance coverage, Your SHIP coverage will be terminated from the 15th of the month following the effective date of that coverage and a pro-rated premium refund will be processed.

If the SHIP office receives Your completed Waiver Application after the effective date of Your qualifying insurance coverage, Your SHIP coverage will be terminated from the 15th of the month following the date the waiver is approved by the SHIP office and a pro-rated premium refund will be processed. Please note that check refunds can take up to 8 weeks to be processed and can only be sent to a U.S. address.

TERMINATIONS AND REFUNDS

Non-Returning International Students or their visa dependents
You or Your visa dependent must provide the SHIP office with a copy of the I-20/DS-2019 prior to the I-20/DS-2019 end date. Your SHIP coverage or Your visa dependents SHIP coverage will be terminated from the 15th of the month following the I-20/DS-2019 end date and a pro-rated premium refund will be processed.
If Your non-visa dependent is leaving the United States, you will need to provide their airline itinerary and payment confirmation in English. Your non-visa dependent's SHIP coverage will be terminated from the 15th of the month following the date of departure from the United States and a pro-rated premium refund will be processed.

If the I-20/DS-2019 does not expire before the end of the current SHIP enrollment period, You will also need to provide the airline itinerary and payment confirmation in English, and ask Your department or academic advisor to send the SHIP office an email prior to the departure date, verifying that You or Your visa dependent is leaving the United States early and not returning on the current visa. Your SHIP coverage or Your visa dependent's SHIP coverage will be terminated from the 15th of the month following the date of departure from the United States and a pro-rated premium refund will be processed.

Non-Returning J-1 scholars or their visa dependents
The SHIP office must receive prior approval from IFSS verifying that You or Your visa dependent is ending the visa early and not returning on the current visa. Your SHIP coverage or Your visa dependent's SHIP coverage will be terminated from the 15th of the month following the amended DS-2019 end date and a pro-rated premium refund will be processed.
If Your non-visa dependent is leaving the United States, you will need to provide their airline itinerary and payment confirmation in English. Your non-visa dependent's SHIP coverage will be terminated from the 15th of the month following the date of departure from the United States and a pro-rated premium refund will be processed.

PLAN CONDITIONS

Covered Student Termination Date

The benefits for a Covered Student will terminate on the first to occur of the following events:

1. The date this Plan terminates,
2. The last day for which any required premium has been paid.

Covered Dependent Termination Date

The benefits for a Covered Dependent will terminate on the first to occur of the following events:

1. The date the coverage for the Covered Student ends or for the Dependent child of a domestic partner, the date the domestic partner no longer qualifies as a Dependent,
2. The first premium due date after any of the following:
   a. The status as a Dependent ends,
   b. Dependent coverage is deleted from this Plan,
   c. At the end of the last period for which any required premium has been paid.

For a Covered Domestic Partner, coverage will terminate on the first to occur of the following events:

1. The Covered Student or domestic partner sends the other a notice for ending the domestic partnership,
2. The Covered Student or domestic partner gets married to another person,
3. The Covered Student and domestic partner stop living together,
4. Dependent coverage is deleted from this Plan, or
5. At the end of the last period for which any required premium has been paid.

The Covered Student must notify this Plan within thirty (30) days if there is any change in the status between the Covered Student and domestic partner as domestic partners. A signed statement of termination of domestic partnership is required.

For incapacitated dependent children who reach the limiting age and who are chiefly dependent upon the Covered Student for support and incapable of self-sustaining employment because of mental or physical handicap, proof of the incapacity and dependency must be furnished to this Plan by the Covered Student within 30 days after coverage would terminate because of age. This Plan may request continuing documentation of incapacity and dependency once a year.

Extension of Benefits

If a Covered Person is confined to a Hospital on the date his or her coverage terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term Eligible Expense, but only while they are incurred during the ninety (90) day period following such termination of coverage.

Coverage For Dependent Child On Medical Leave Of Absence

If coverage is provided for a Dependent child as defined in this Plan, coverage may be provided for such Dependent who is a full-time student who takes a leave of absence from school due to Illness for a period of up to twelve months from the last day of attendance in school, provided the attending Physician certifies that the leave of absence is Medically Necessary. The premium charged for such extended coverage for him or her may not exceed the premium charged while such Dependent is enrolled as a full-time student. In no event will coverage continue beyond the date or age at which coverage would otherwise terminate.

PLAN CONDITIONS

Pre-Certification Process

In-Network - Your In-Network Provider is responsible for obtaining any necessary Pre-certification before You receive the care. If Your In-Network Provider does not obtain the required Pre-Certification you will not be penalized. Please read below regarding review and notification.

Out-of-Network - You or Your Out-of-Network Provider are responsible for calling Us at the **phone number found on the back of Your ID card** and starting the Pre-Certification process. If Your Out-of-Network Provider does not obtain the required Pre-Certification you will not be penalized. For Inpatient services the call must be made at least 5 working days prior to Hospital Confinement. or Outpatient services, the call must be made at least 5 working days prior to the start of the Outpatient service. In the case of an emergency, the call must take place as soon as reasonably possible.

The following Inpatient and Outpatient 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 a substance use disorder, 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. Home Health Care;
5. Durable Medical Equipment over $500;
6. Surgery;
7. Sleep Management
8. Transplant Services;
9. Infusions/Injectables;
10. Botox injections;
11. Orthotics/prosthetics;
12. Transcranial Magnetic Stimulation (TMS);
13. Physical Therapy (Outpatient) precertification required after the 12th visit
14. Occupational Therapy (Outpatient precertification required after the 12th visit
15. Chiropractic Services (Outpatient) precertification required after the 12th visit

Pre-Certification is not required for an Emergency Medical Condition or Urgent Care or Hospital Confinement for the initial 48/96 hours of maternity care.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by In-Network Providers.

Pre-Certification is not a guarantee that Benefits will be paid.

Pre-Certification Process, continued
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 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 or by telephone;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing or by telephone regarding Our decision.

Our agent will make this determination within 72 hours for an urgent request and 4 business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Benefit Determination made by Our agent will be in writing and will include:
1. The reasons for the Adverse Benefit Determination including the clinical rationale, if any.
2. Instructions on how to initiate an appeal.
3. Notice of the availability, upon Your request or Your Authorized Representative, of the clinical review criteria relied upon to make the Adverse Benefit Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

Failure by Our agent to make a determination within the time periods prescribed shall be deemed to be an Adverse Benefit Determination subject to an appeal.

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

PLAN CONDITIONS

Claim Submission and Timely Filing Period

Written notice of claim and proof of loss (including submission of Incomplete Claims) must be given to this Plan within thirty (30) days after the occurrence or commencement of any loss covered by this Plan, or as soon thereafter as is reasonably possible, but no later than six months from the incurred service date. Notice given by or on behalf of the claimant or beneficiary to this Plan or authorized claims payor with information sufficient to identify the Covered Person shall be deemed "notice."

A completed claim form should be attached to the submitted expense. Claims should be submitted to:

The Alliance Claims Dept.
P.O. Box 44365
Madison, WI 53744-4365

Claim Forms

A fully completed claim form must be submitted if requested by the Third Party Administrator. The claim form should include current mailing address, student status (as applicable) and information regarding any other plan of benefits under which the Covered Person may be enrolled. Additional claim forms should be submitted on a Covered Person whenever that person experiences a change in student status, is enrolled or terminated from another health benefit plan, or incurs expenses related to an Accident or Injury in order to provide details of the Accidental Injury. Claim forms may also be requested by this Plan at any time to provide information required to determine if a Claim is Eligible or Covered.

Incomplete Claims

This Plan has the right to delay or deny reimbursement on any Incomplete Claim. Incomplete Claim means any claim which cannot be determined to be an Eligible or Covered Expense as a result of a lack of information pertaining to the Claimant's eligibility to participate in this Plan, the service(s) rendered, the diagnosis, application of this Plan's Right of Recovery or Subrogation clause, details of any Accidental Injury, or any other reason which may be reasonably pertinent for a benefit determination.

Pre-Determination of Benefits

There are circumstances in which a Covered Person, his or her health care provider or other appropriate representative of the patient may request a pre-determination of coverage prior to the initiation of a Treatment or procedure. Any pre-determination of coverage issued by this Plan is not a guarantee of benefits; benefits will be paid in accordance with Plan provisions in effect at the time services were rendered, patient eligibility, Plan exclusions and Plan limitations.

CLAIMS PROCEDURES AND REGULATIONS

Large Case Management

Often it is most efficient and more convenient for both this Plan and the family of the Covered Person to have this Plan provide active management of care and its delivery. When a covered Person has been identified with a medical condition or catastrophic Illness, that Covered Person may require long term or lifetime care, or complicated patterns of care. In addition, when medical care costs for a particular condition are expected to exceed a certain dollar amount, and there is a potential for alternative treatment or an alternative setting, then the case may be referred for Large Case Management (LCM).

LCM is a program which provides an individual case analysis and medical treatment plan recommendations to address the needs of the catastrophically ill or injured individual. The decision to implement LCM will be determined by the Third Party Administrator in coordination with the Third Party Administrator's Case Management (vendor or provider). A case manager will contact the Covered Person and/or family to explain about case management. The case manager, team of Physicians and rehabilitation nurses work with the Attending Physician and the Covered Person to develop a cost effective, long term plan of care that maximizes Plan resources, eliminates excess services and meets the individual Covered Person's needs. In certain circumstances, a recommendation to use alternative treatment, some of which may not normally be covered by this Plan, may be suggested when such treatment endorses quality care, Medical Necessity and cost effectiveness. Under these circumstances any such suggested alternative treatment will be covered by this Plan. The patient and family are required to review the recommended alternative treatment plan. The final determination regarding the services to be rendered is the decision of the patient and/or family and the Attending Physician. There is no reduction of benefits or penalties imposed if the patient and family choose not to participate.

Independent Medical Examination

An Independent Medical Examination (IME) is a consultation, examination or records review requested by the Third Party Administrator on any Covered Person. An IME is most often used to determine medical necessity or the experimental/investigational nature of a Treatment plan or procedure. If a Covered Person fails to attend a scheduled IME without good cause, his or her benefits for that Treatment plan or procedure, or related care, may be suspended or denied.

COORDINATION OF BENEFITS

This section will be used to determine a Covered Person's benefits under this Plan if:

(a) the person is insured for medical care benefits under this Plan and is also covered for these benefits under other plans; and

(b) the benefits that would be paid by this Plan, without this section plus the benefits that would be paid by the other plans, without a section similar to this section would exceed Allowed Expenses as defined below.

Definitions

"Other Plan" means a plan which provides benefits or services for, or by reason of Hospital, surgical, medical (including treatment for mental health and chemical dependency), or dental care or treatment through:

1. any other group, blanket or franchise insurance coverage;

2. pre-paid plans for:
   - group Hospital service
   - group medical service
   - group practice
   - individual practice and
   - any other such plans for members of a group;

3. any plan provided by:
   - labor management trusts
   - unions
   - employer organizations
   - professional organization, or
   - employee benefit organizations;

4. a government program or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;

5. any part of a state auto reparation or indemnity act ("no fault insurance") with which the state permits coordination; and

6. insurance coverage provided by the National Collegiate Athletic Association (NCAA) or the National Association of Intercollegiate Athletics (NAIA); or any coverage provided by the University of Wisconsin Athletic Department.

   This Plan does not cover nor provide benefits for expenses incurred for injury resulting from the play or practice of intercollegiate sports for which benefits are paid under insurance coverage provided by the NCAA or the NAIA; or any coverage provided by the University of Wisconsin Athletic Department. Any Medically Necessary Eligible Expenses provided for under this Plan and not paid for under insurance coverage provided by the NCAA, NAIA; or the University of Wisconsin Athletic Department Plan will be payable under this Plan. The total benefits paid under all plans cannot exceed 100% of the Eligible Expenses incurred.

COORDINATION OF BENEFITS

"This plan" means the medical care benefits provided by this Plan.

"Allowed Expense" means an Expense which is:
- necessary, Usual and Customary;
- incurred while the person for whom the claim is made is insured, or is entitled to benefits after insurance ends, under this Plan;
- at least partly covered under one of the plans covering such person.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room shall not be deemed to be an Allowed Expense unless the patient's stay in a private room is Medically Necessary in terms of generally accepted medical practice.

When this Plan does not pay its benefits first, "Allowed Expense" will not include an Expense which is not paid because of the claimant's failure to comply with the cost containment requirements of the plan which pays its benefits first.

When a plan provides a benefit as a service rather than a cash payment, the reasonable cash value of the service will be considered to be both an Allowed Expense and a benefit paid.

Effects On Benefits Under This Plan
When this section is used, the rules listed below will determine the amount of benefit each plan will pay. All benefits will be determined on a Plan Year basis.

These rules may require this plan to pay its benefits first. If so, this plan will pay its full benefits without taking into account other plan benefits. These rules may require one or more of the other plans to pay their benefits before this plan. If so, this plan will reduce its benefits so that in any Plan Year, the sum of all benefits to be paid to a person (by this and all other plans) equals the Allowed Expenses for that year. Benefits to be paid under other plans include benefits that would be paid if proper claim is made for such benefits.

Rules to Determine which Plan Pays First
A plan, or part of one, that does not have a section similar to this section will pay its benefits before a plan that has such a section.

In all other cases, the plan that will pay its benefits first will be dependent upon the first applicable rule:
1. The plan that does not reserve the right to take this Plan's benefits into account in figuring its own benefits will always be primary.
2. The plan which covers the Covered Person as an employee; rather than as a full or part- time student.
3. If 2 does not apply, the plan which covers the person as a full or part-time student rather than as a Dependent.
4. If 1, 2, and 3 do not apply, the plan which covers the person as a Dependent of the parent whose month and day of birth occurs earlier in the year. If the other plan has a rule based on the gender of the parent, the gender rule will determine the order of benefits. However, a child's parents may be divorced or separated. If so, the plan to pay its benefits first will be the plan which covers the child as a Dependent of the parent with custody rather than as a Dependent of the parent without custody.

COORDINATION OF BENEFITS

If the parent with custody remarries:

- the plan which covers the child as a Dependent of a parent with custody will pay its benefits first,
- the plan which covers the child as a Dependent of a stepparent will pay its benefits next, and
- the plan which covers the child as a Dependent of a parent without custody will pay its benefits last.

For a Dependent child of separated or divorced parents, the following governs which plan pays first when the person is a Dependent of a student:

(a) when a court order makes one parent financially responsible for the health care expenses of the Dependent child, then that parent's plan pays first;

(b) if there is no such court order, then the plan of the natural parent with custody pays before the plan of the stepparent with custody; and

(c) the plan of the stepparent with custody pays before the plan of the natural parent without custody.

Item 1 will not apply unless a similar provision is contained in all plans. In this case item 2, 3, or 4 will determine which plan pays first.

If none of the above apply, then the plan which has covered the Covered Person for the longer time rather than the shorter time pays first.

If the benefits of this plan are reduced due to these rules, such reduction will be done in proportion. Any benefits paid by this plan on a reduced basis will be charged against the benefit limits of this plan.

Right to Receive and Release Necessary Information

For this section to work, the University must exchange information with other plans. To do so, the University may give to or get from any source all such information it thinks necessary. This will be done without the consent of or notice to any person except as required by the applicable state statute. Any person claiming benefits under this plan must give the University the information it requires.

Facility of Payment

Another plan may pay a benefit that should be paid by this Plan by the terms of the provision. If this happens, the University may pay to such payer the amount required for it to satisfy the intent of this provision. This will be done at the University's discretion. Any amount so paid will be considered a benefit under this plan. The University will not be liable for such payment after it is made.

GENERAL PROVISIONS

Fiduciary Liability
To the extent permitted by law, neither the Plan Administrator nor any other person shall incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

Compensation of Plan Administrator
Any Plan Administrator who is also an employee of the University shall service without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the University.

Payment of Administrative Expenses
Unless otherwise indicated in the Adoption Agreement, all reasonable expenses incurred in administering this Plan shall be paid by this Plan.

Funding Policy
This Plan shall have the right to enter into a contract with one or more insurance companies for the purposes of providing any benefits under this Plan and to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments or other refunds of any type that may become payable under any such insurance contract shall not be assets of this Plan but shall be the property of, and shall be retained by the Plan Administrator.

Reporting and Disclosure Requirements
Unless specified otherwise, it shall be the Plan Administrator's sole responsibility to comply with all filing, reporting, and disclosure requirements. Furthermore, the Plan Administrator shall be required to amend this Plan as is necessary to ensure compliance with applicable tax and other laws and regulations.

Indemnification
The Plan Administrator shall be indemnified by the University against claims, and the expenses of defending against such claims, resulting from any action or conduct relating to the administration of this Plan except claims arising from gross negligence, willful neglect, or willful misconduct.

Applicable Laws
The provisions of this Plan shall be construed, administered and enforced according to applicable Federal law.

Post-Mortem Payments
Any benefit payable under this Plan after the death of a Participant shall be paid to his or her surviving spouse (if any), otherwise, to his or her estate. If there is doubt as to the right of any beneficiary to receive any amount, the Plan Administrator may retain such amount until the rights thereto are determined, without liability for any interest thereon.

GENERAL PROVISIONS

Mental or Physical Incompetency
Every person receiving or claiming benefits under this Plan shall be presumed to be mentally and physically competent and of age until the Plan Administrator receives written notice, in a form and manner acceptable to it, that such person is mentally or physically incompetent or a minor, and that a guardian, conservator or other person legally vested with the care of his or her estate has been appointed.

Inability to Locate Payee
If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under this Plan because he or she cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

Requirement for Proper Forms
All communications in connection with this Plan made by a Participant shall become effective only when duly executed on any forms as may be required and furnished by, and filed with, the Plan Administrator.

Source of Payments
This Plan and any insurance company contracts purchased or held by this Plan or funded pursuant to this Plan shall be the sole sources of benefits under this Plan. No student or beneficiary shall have any right to, or interest in, any assets of this Plan upon termination or otherwise, except as provided from time to time under this Plan, and then only to the extent of the benefits payable under this Plan to such student or beneficiary.

Multiple Functions
Any person or group of persons may serve in more than one fiduciary capacity with respect to this Plan.

Tax Effects
Neither the University, its agents, this Plan nor the Plan Administrator makes any warranty or other representation as to whether any amount paid for the benefit of a Participant or beneficiary are includable in any gross income for local, federal or state income tax purposes. Under no circumstances shall the recipient have any recourse against the Plan Administrator, this Plan or the University with respect to any increased taxes or other losses or damages suffered by the Covered Person as a result thereof.

Gender and Number
Masculine pronouns include the feminine as well as the neuter genders, and the singular shall include the plural, unless indicated otherwise by the context.

Headings
Article and section headings contained herein are for convenience of reference only and shall not be construed as defining or limiting the matter contained hereunder.

GENERAL PROVISIONS

Severability
Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder thereof shall be given effect to the maximum extent possible.

Provisions Relating to Insurers
No insurer shall be required or permitted to issue an insurance policy or contract that is inconsistent with the purposes of this Plan, nor be bound to take any action not in accordance with the terms of any policy or contract with this Plan. The insurer shall not be deemed to be a party to this Plan, nor shall it be bound to interpret the construction or validity of this Plan. The insurer shall be protected from its good faith reliance on the written representations and instructions of the Plan Administrator, and shall not be responsible for the initial or continued qualified status of this Plan.

Right of Recovery
In the event that this Plan paid benefits that should be paid by another Plan or any other source or that are later found to be greater than the allowable charge or were ineligible, this Plan may seek reimbursement. In such cases, this Plan may recover the amount incorrectly paid from the other benefit plan, the source to which it was paid or by the withholding of any amounts due this Plan from future benefit reimbursements of the participant.

Right of Subrogation and Refund
This provision applies when a Covered Person incurs health care expenses due to injuries or Illnesses caused by the act or omission of a third party or any party or source which may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, insurer or any other source for payment of the health care expense or for pain and suffering.

As a condition of receiving benefits under this Plan, a Covered Person automatically assigns and transfers to this Plan any rights the Covered Person may have to recover payments from any third party or insurer (including, but not limited to, such Covered Person's own insurer(s)), for funds paid or payable under this Plan as a result of personal Injury or reimbursement of health care expenses. Further, in the event the Covered Person receives any funds from a judgment, settlement or otherwise from any other person, business entity or any other source, or such aforementioned funds are placed in a trust or other similar arrangement, the Covered Person, the trust or similar arrangement shall first repay this Plan in full as the first priority party, for any benefits paid by this Plan.

As a condition of receiving benefits under this Plan, a Covered Person recognizes, transfers, conveys and otherwise authorizes this Plan to directly pursue any claim which the Covered Person has against any third party, insurer or any other source, whether or not the Covered Person chooses to pursue that claim.

The Covered Person agrees to recognize this Plan's right to subrogation and reimbursement. These rights provide this Plan with a priority over any funds paid by a third party, insurer or any other source, including the Covered Person's own uninsured/underinsured motorist coverage, to a Covered Person, trust or similar arrangement relative to the Injury or Illness, including a priority over any claim for non-medical/dental/prescription/vision charges (pain and suffering claims, other damages), attorney fees, or other costs and expenses. This

Right of Subrogation and Refund, continued
priority shall be enforceable even if the Covered Person is not made whole by the available recoveries, and shall be considered a lien against such recoveries until this Plan is repaid in full.

This Plan's priority to funds, subrogation and refund rights, and any/all rights assigned to it is limited to the extent to which this Plan has made, or will make, payments for medical/dental/vision/prescription charges, or any other health care expenses, as well as any costs and fees associated with the enforcement of its rights under this Plan. Covered Person(s) under this Plan must: (1) inform this Plan in writing within sixty (60) days of their claim against third parties, or other entities and/or insurers for benefits, (2) furnish information and assistance regarding the existence and status of such claims, and (3) execute any documents as this Plan may require to enforce its rights under this Plan. The Covered Person also agrees to take no action which may prejudice the rights or interest of this Plan. Failure to comply with these provisions may result in the Covered Person being personally responsible for reimbursing this Plan, and/or lead to a denial of all further Plan Benefits.

Premiums
This Plan sets the premiums that apply to the coverage provided under this Plan. This Plan has the right to adjust these rates each Plan Year or when the benefits or terms of this Plan are changed. The Covered Student or continuing person will be given notice of such adjustment.

Renewal of Coverage
With this Plan's consent, coverage may be renewed for like periods by payment of the renewal premium at the rate in effect at that time. This renewal premium must be paid on or before the last date of the applicable enrollment period. This Plan also has the right to refuse to renew coverage.

SCHEDULE OF BENEFITS

Primary Care Provider (UHS)	**University Health Services (UHS) Clinical Services & University Health Services Counseling & Consultation Services**
Applies to	The Covered Student and the Covered Spouse/Domestic Partner
Primary Care	0% no deductible or copayment
Urgent Care	0% no deductible or copayment **Urgent Care** means care for an unexpected Illness or Injury which does not require use of a Hospital's Emergency Room, but which may need prompt attention, includes, but is not limited to: cold, sore throat, cough, fever, vomiting, sprain or strain, cramps, diarrhea, bumps and bruises, small lacerations, minor burns, earache, rashes, swollen glands, conjunctivitis.

Benefit	**Primary Care Provider (UHS)** Covered Students and Covered Spouses/Partners must use UHS for all eligible Preventive Care.*	**Network Provider**	**Out-of-Network**
Accident and Illness Aggregate Benefit Maximum Some benefits may have additional dollar or visit maximums or confinement maximums.	Unlimited All services incurred as a result of the Accident or Illness – facility, physician, radiology, pathology, ambulance, covered supplies and equipment and prescription medications. Refer below for rate of Eligible Expense reimbursement.		
Plan Year Deductible	Not Applicable	$150.00 per person $300.00 per family	$ 500.00 per person $ 1,000.00 per family
Out-of-Pocket Maximum (Coinsurance, Copayments and Deductible) Combined Network Provider and Out-of-Network maximum of $3000 per person or $6000 per family.	Not Applicable	$ 3,000.00 per person $ 6,000.00 per family	$ 6,000.00 per person $12,000.00 per family

SCHEDULE OF BENEFITS

Benefit	**Primary Care Provider (UHS)** Covered Students and Covered Spouses/Partners must use UHS for all eligible Preventive Care.*	**Network Provider**	**Out-of-Network**
Hospital Facility Services Room & Board (semi-Private, ICU, CCU) Hospital Ancillary Excludes personal and convenience items. Emergency hospital admissions to an Out-of-Network facility as a result of a medical emergency will be considered at the Network Provider benefit rates subject to UCR. **Pre-certification required**	Not Applicable	10% after deductible 10% after deductible	40% after deductible 40% after deductible
Services Provided by a QualityPath Provider* **Knee Replacement** **Hip Replacement** ***Pre-notification required. Member must call 800-223-4139 prior to services being rendered.**	Not Applicable	0%, no deductible	Not Applicable
Skilled Nursing Facility & Inpatient Rehabilitation Facility Following an acute inpatient care confinement. Custodial care is excluded. **Pre-certification required**	Not Applicable	10% after deductible	40% after deductible
Outpatient Hospital Short Procedures Unit or Ambulatory Surgery Other Covered Expenses	Not Applicable	10% after deductible 10% after deductible	40% after deductible 40% after deductible

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

SCHEDULE OF BENEFITS

Benefit	Primary Care Provider (UHS) Covered Students and Covered Spouses/Partners must use UHS for all and eligible Preventive Care.*	Network Provider	Out-of-Network
Emergency Room Medical Emergency ($100 copay waived if admitted)	Not Applicable	$100 copay, then 0% after the Network Provider deductible	$100 copay, then 0% after the Network Provider deductible
Non-Medical Emergency **Includes emergency room facility, emergency room physician, radiologist, pathologist.** ($100 copay waived if admitted)	Not Applicable	$100 copay, then 10% after deductible	$100 copay, then 40% after the deductible
Urgent Care Center **(non-hospital provider)**	Not Applicable	10% after deductible	40% after deductible
Pre-Admission Testing	Not Applicable	10% after deductible	40% after deductible
Diagnostic Laboratory (outpatient)	No charge when ordered by UHS providers	10% after deductible	40% after deductible
Diagnostic Testing & X-ray (outpatient)	No charge when a UHS provider is the treating clinician.	10% after deductible	40% after deductible
CAT Scan, MRI and/or PET Scan **Pre-certification required**	Not Applicable	10% after deductible	40% after deductible
Services Provider by a QualityPath Provider **CAT Scan** MRI Scan	Not Applicable	0%, no deductible	Not Applicable
Home Health Care Limited to 60 visits per Plan Year. Custodial care is excluded. Pre-certification required	Not Applicable	10% after deductible	40% after deductible

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

SCHEDULE OF BENEFITS

Benefit	Primary Care Provider (UHS) Covered Students and Covered Spouses/Partners must use UHS for all eligible Preventive Care.*	Network Provider	Out-of-Network
Hospice Care	Not Applicable	10% after deductible	40% after deductible
Physician/Specialist Services			
Inpatient	Not Applicable	10% after deductible	40% after deductible
Surgery Pre-certification required	Not Applicable	10% after deductible	40% after deductible
Anesthesiologist Pre-certification required	Not Applicable	10% after deductible	40% after deductible
Office & Clinic Visits	No Charge	10% after deductible	40% after deductible
Allergy Injection	No Charge	10% after deductible	40% after deductible
Congenital Heart Disease Surgery Pre-certification required	Not Applicable	10% after deductible	40% after deductible
Kidney Disease & Kidney Transplant Benefit All services incurred as a result of disease and transplant – facility, physician, radiology, pathology, dialysis, covered supplies and equipment and prescription medications. Pre-certification required	Not Applicable	10% after deductible	40% after deductible
Organ & Tissue Transplant Lifetime Benefit All services incurred as a result of organ and tissue transplant – facility, physician, radiology, pathology, covered supplies and equipment and prescription medications. Pre-certification required	Not Applicable	10% after deductible	40% after deductible
Rehabilitative Services/Habilitative Services			
Physical Therapy – Limited to 40 Visits per Illness or Injury per Plan Year Pre-certification required after 12th visit	No Charge	10% after deductible	40% after deductible
Occupational Therapy – Limited to 40 Visits per Illness or Injury per Plan Year Pre-certification required after 12th visit	Not Applicable	10% after deductible	40% after deductible
Speech Therapy – Limited to 20 Visits per Illness or Injury per Plan Year	Not Applicable	10% after deductible	40% after deductible
Cognitive Rehabilitation – Limited to 20 Visits per Illness or Injury per Plan Year	Not Applicable	10% after deductible	40% after deductible

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

SCHEDULE OF BENEFITS

Benefit	Primary Care Provider (UHS) Covered Students and Covered Spouses/Partners must use UHS for all eligible Preventive Care.*	Network Provider	Out-of-Network
Chiropractic Care & Spinal Manipulation Includes all Medically Necessary services rendered by a chiropractor. Also includes Medically Necessary therapeutic manipulations and related services rendered by a D.O. Short-term therapy only. Pre-certification required after 12th visit	Not Applicable	10% after deductible	40% after deductible
Well Child Care This benefit is available from birth to age 18. Includes well child routine physical health examinations (except when required by a third party), screening, screening laboratory, x-ray (such as urinalysis and blood tests) and office visits.	Not Applicable	No charge for Preventive Services specified by the Patient Protection and Affordable Care Act (PPACA)- click here for details (if you have additional questions please call the SHIP Claims Administrator, Wellfleet at 1-877-657-5031); otherwise, 10% after deductible	40% after deductible
Preventive Care (Dependent children 18 and over) Covered services include: one annual well woman examination, one annual pap smear, routine preventive physical examinations, cholesterol screening, HIV and STI screening and smoking cessation assistance. This Plan also covers immunizations (including travel, meningitis and HPV vaccines).	Not Applicable	No charge for Preventive Services specified by the Patient Protection and Affordable Care Act (PPACA)- click here for details (if you have additional questions please call the SHIP Claims Administrator, Wellfleet at 1-877-657-5031); otherwise, 10% after deductible	40% after deductible

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

SCHEDULE OF BENEFITS

Benefit	Primary Care Provider (UHS) Covered Students and Covered Spouses/Partners must use UHS for all eligible Preventive Care.*	Network Provider	Out-of-Network
Child Immunizations This benefit is available from birth to age 18. Covered immunizations include diphtheria, pertussis, tetanus, polio, measles, mumps, rubella, hemophilus influenza B, hepatitis B and varicella.	Not Applicable	No charge for Preventive Services specified by the Patient Protection and Affordable Care Act (PPACA)- click here for details (if you have additional questions please call the SHIP Claims Administrator, Wellfleet at 1-877-657-5031); otherwise, 0%, no deductible	0%, no deductible
Preventive Care (Student/spouse/partner) UHS covered services include: one annual well woman examination, one annual pap smear, routine preventive physical examinations, cholesterol screening, HIV and STI screening and smoking cessation assistance. The Plan also covers immunizations (including travel, meningitis and HPV vaccines) and HIV pre-exposure prophylaxis.	No Charge	No Charge for Preventive Services specified by Patient Protection and Affordable Care Act (PPACA) that are not available at UHS- click here for details (if you have additional questions please call the SHIP Claims Administrator, Wellfleet at 1-877-657-5031); otherwise, Must utilize UHS*	Must utilize UHS*

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

SCHEDULE OF BENEFITS

Benefit	Primary Care Provider (UHS) Covered Students and Covered Spouses/Partners must use UHS for all eligible Preventive Care.*	Network Provider	Out-of-Network
Pediatric Vision Care - (Covered Persons under age 19 only)			
Copayment per visit:			
Examination	Not Applicable	$25	$25
Materials	Not Applicable	$25	$25
Coinsurance	Not Applicable	20% after deductible	20% after deductible
Maximum Amount:			
Standard Lenses:			
Single Vision	Not Applicable	$50	$50
Bifocal	Not Applicable	$50	$50
Trifocal	Not Applicable	$50	$50
Lenticular	Not Applicable	$50	$50
Progressive	Not Applicable	$50	$50
Frames	Not Applicable	$100	$100
Contact Lenses (in lieu of eyeglasses and frames)			
Effective	Not Applicable	$100	$100
Medically Necessary	Not Applicable	$100	$100
Pediatric Dental Treatment (Covered Persons under age 19 only)			
Basic Services: • For Diagnostic and Treatment Services • For Preventive Services • Additional Procedures coverage as Basic Services	Not Applicable	50% after deductible	50% after deductible
Intermediate Services: • For Minor Restorative Services • For Endodontic Services • For Periodontal Services • For Prosthodontic Services • For Oral Surgery	Not Applicable	50% after deductible	50% after deductible
Major Services: • For Major Restorative Services • For Endodontic Services • For Periodontal Services • For Prosthodontic Services	Not Applicable	50% after deductible	50% after deductible
Orthodontic Services: • For Orthodontic Services	Not Applicable	50% after deductible	50% after deductible

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

SCHEDULE OF BENEFITS

Benefit	Primary Care Provider (UHS) Covered Students and Covered Spouses/Partners must use UHS for all eligible Preventive Care.*	Network Provider	Out-of-Network
Screening Mammography (not otherwise covered under the Preventive Care benefit) One baseline mammogram is covered between the ages of 35 and 40, once every two years between the ages of 40 and 50, and annually age 50 and over. A Covered woman with a personal or family history of breast cancer or biopsy proven benign breast disease, or having a first child after age 30 may be covered for this service on a more frequent basis upon a Physician's referral.	Not Applicable	10% after deductible	40% after deductible
Mental Health and Chemical Dependency (covered on the same basis as any other Illness)			
Inpatient	Not Applicable	10% after deductible	40% after deductible
Partial Hospitalization (Also known as transitional care.)	Not Applicable	10% after deductible	40% after deductible
Outpatient/office/clinic (Covered providers include M.D., D.O., Ph.D., Ed.D.)	No charge	10% after deductible	40% after deductible
Diabetic Education and Supplies Limited to one consultation per Plan Year	Not Applicable	10% after deductible	40% after deductible
Ambulance Transport For ground and air transport only when for a life threatening medical emergency to the nearest hospital facility.	Not Applicable	10% after deductible	10%
Private Duty Nursing Medically Necessary Only	Not Applicable	10% after deductible	40% after deductible
Extraction of Natural Teeth and Replacement with Artificial Teeth Because of Accidental Injury	Not Applicable	10% after deductible	40% after deductible
Durable Medical Equipment	Not Applicable	10% after deductible	40% after deductible

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

SCHEDULE OF BENEFITS

Benefit	Primary Care Provider (UHS) Covered Students and Covered Spouses/Partners must use UHS for all Primary Care, Urgent Care and eligible Preventive Care.*	Network Provider	Out-of-Network
Gender Reassignment Benefit Medically Necessary changes incurred for gender reassignment treatments will be paid the same as any other covered condition, including but not limited to: gender reassignment surgery, physician's visits, laboratory tests and outpatient prescription drugs (including hormones and hormone therapy). **Pre-certification required**	Not Applicable	10% after deductible	40% after deductible
Outpatient Prescription Drug Benefit	**Must use SHIP Membership Card to receive benefit.**		
Formulary Generic (Tier 1) Formulary, Brand Name (Tier 2) Non-Formulary, Brand (Tier 3) Specialty Drugs	**Copayment** $10.00 copayment $25.00 copayment $40.00 copayment 10% up to a maximum of $150 per fill		No coverage
Contraceptive Benefit – This benefit applies to all prescribed FDA-approved birth control methods (not subject to Copayment)	**Days supply** Up to a 31 day supply per fill for all eligible retail pharmacy medications. No charge for prescribed FDA-approved contraceptives. Note – unless a brand name contraceptive is prescribed as Medically Necessary, a copayment will apply if a member receives a brand name contraceptive when a generic equivalent is available.		

*Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.

MEDICAL BENEFITS

Accident and Illness Aggregate Benefit Maximum

This Plan will reimburse for Eligible Expenses incurred as a result of Covered Illness or Accidental Injury to an unlimited aggregate maximum per Covered Person. “Each Illness” or “Each Injury” is defined as an Illness or Injury and all recurrences and related conditions which are sustained by a Covered Person. All reimbursements made by this Plan including facility charges, Physician, other health care providers and professionals, radiology, pathology, ambulance transportation, covered supplies, eligible medical equipment and prescription medications are applied toward the unlimited aggregate maximum. Other types of benefits may have additional dollar or visit maximums or confinement maximums.

Kidney Disease, Kidney Transplant, Organ and Tissue Transplant Services

This Plan will cover human to human organ and tissue and bone marrow transplant services and procedures. Covered solid organ transplant procedures include transplants of liver, heart, heart/lung, lung, kidney, pancreas , kidney/pancreas, small bowel, and other solid organ transplant procedures which the Third Party Administrator determines to have become standard, effective practice and have determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. Such solid organ transplants will be considered on a case by case basis. Covered tissue transplant procedures (autologous and allogeneic) blood transfusions, autologous parathyroid transplants, corneal transplants, bone and cartilage grafting, skin grafting, autologous islet cell transplants; and other tissue transplant procedures which the Third Party Administrator determines to have become standard, effective practice and have been determined to be effective procedures by peer review literature as well as other resources used to evaluate new procedures. Such tissue transplants will be covered on a case by case basis. Certain bone marrow procedures will be covered when the recipient is a Covered Person under this Plan. Covered bone marrow transplants include allogeneic, autologous and syngeneic bone marrow transplants, including tandem transplants, mini transplants (transplant lite) and donor lymphocyte infusions. The charges must be incurred while covered under this Plan. Donor expenses when the recipient is a Covered Person under this Plan will be considered secondary to any benefits payable under the Donor’s Plan and only for expenses incurred for the evaluation, removal, and transportation of the organ. Donor expenses when the recipient is not a Covered Person under this Plan are excluded.

In general, Eligible Expenses include:

1. Organ and tissue procurement consisting of removing, preserving and transporting the donated part and tissue typing for related or unrelated donors;
2. Hospital room and board and medical supplies;
3. Diagnosis, treatment, surgery and follow-up care by a Physician;
4. Home care subject to provisions for coverage described under that section of this Document;
5. Rental to purchase price of wheel chairs, hospital beds and mechanical equipment as is Medically Necessary;
6. Local ambulance service for Medically Necessary transports;
7. Medication, radiology, other diagnostic and laboratory tests;
8. Physical, occupational and speech therapy when Medically Necessary subject to provisions as described under that section of this document.

MEDICAL BENEFITS

The Plan Year Deductible

The Plan Year Deductible is the amount of Eligible Expenses which must be paid by the Covered Person before benefits under this Plan will begin. The Deductible is paid only once per Plan Year per Covered Person. When the total amount of Deductible applied per all Covered Persons in a family unit equals the Family Deductible, then the deductible is considered to have been met for the entire family. Non-covered services, copayments and coinsurance do not apply towards the Plan Year Deductible.

Out-of-Pocket Maximum

Coinsurance is the term used to describe the amount of Eligible Expenses for which the Covered Person is generally responsible after application of the Plan Year Deductible. Generally, this Plan will pay 90% of the network allowance for covered In-Network expenses and 60% of Usual, Customary and Reasonable (UCR) for Out-of-Network care. The 10% or 40% remaining after this Plan reimburses is the Covered Person's Coinsurance. Copayments, Plan Year Deductible and Coinsurance combined are called Out-of-Pocket. This Plan limits a Covered Person's Out-of-Pocket responsibility to a maximum amount per Covered Person. When the total amount of Out-of-Pocket applied per all Covered Persons in a family unit equals the Family Out-of-Pocket maximum, then the Out-of-Pocket maximum is considered to have been met for the entire family. Non-covered services and charges in excess of UCR charges do not apply towards the Out-of-Pocket Maximum. The In-Network and Out-of-Network Out-of-Pocket amounts are linked in that amounts applied to In-Network Out-of-Pocket are credited towards the Out-of-Network and vice versa.

Inpatient Hospital Facility

This Plan will consider Eligible Expenses incurred during a period of hospital confinement which is Medically Necessary up to any applicable confinement maximum. Charges for a private room are limited to the hospital's prevailing semi-private room rate. Expenses for personal and convenience items, including but not limited to, television, telephone, hygiene products, robes, slippers, socks, are not covered. Coverage includes Medically Necessary hospital charges for:

1. Semi-private room and board;
2. General nursing care;
3. Private duty nursing care;
4. Drugs, medications and biologicals while confined;
5. Patient meals, including special diets when necessary;
6. Use of operating room and related facilities;
7. Use of intensive care or cardiac units and related services;
8. Oxygen services;
9. Administration of whole blood and blood plasma, including the processing and preparation;
10. Necessary supplies, appliances and equipment.

In the event of an emergency admission as a result of a life threatening medical emergency, this Plan will consider Eligible Expenses of an Out-of-Network facility if it was the nearest hospital facility at the In-Network rate limited to UCR.

MEDICAL BENEFITS

Skilled Nursing and Inpatient Rehabilitation Confinement

Eligible Expenses for a skilled nursing facility or inpatient rehabilitation confinement are covered. In order to be eligible, such confinement must:

1. Follow an inpatient hospital confinement,
2. Occur within twenty-four (24) hours of discharge from such hospital confinement,
3. Be required to provide recuperative nursing care and/or rehabilitation services for the condition that caused the initial hospital confinement, and
4. Have been considered an Eligible Expense had the Covered Person remained hospital confined versus discharge with appropriate home care services.

Skilled Nursing and Inpatient Rehabilitation confinement is limited to semi-private accommodations or an allowance equal to the prior hospital facility's most frequent established charge for semi-private rooms, whichever is less. Inpatient rehabilitation is limited to short term treatment for conditions which will result in significant improvement based on the treatment plan prescribed and is not covered for chronic problems or routine maintenance for chronic conditions.

Outpatient Hospital

Covered Services rendered by the outpatient department of a Hospital facility will be covered as shown on the schedule of Benefits and as may be described elsewhere in this document. Services include, but are not limited to:

1. Use of the hospital's Short Procedures Unit or an Ambulatory Surgery Center for Covered surgical procedures;
2. Diagnostic, laboratory and x-ray services (refer to Diagnostic X-ray, Testing and Laboratory);
3. Chemotherapy and Radiation Therapy services (refer to Other Covered Services); and
4. Dialysis (refer to Other Covered Services as well as Kidney Disease and Kidney Transplant).

Emergency Room

This Plan will cover the cost of a Hospital's Emergency Room as shown on the Schedule of Benefits, including Medically Necessary charges made by the Emergency Room Physician, radiologist and pathologist. In the event of a life threatening medical emergency, the Covered Person should seek treatment from the nearest available hospital facility. A copayment of $100 will be applied to any emergency room visit.

Urgent Care Centers

This Plan will cover the cost of non-hospital urgent care centers as shown on the Schedule of Benefits.

MEDICAL BENEFITS

Pre-Admission Testing
This Plan encourages participants to obtain Pre-Admission Testing (PAT) prior to the beginning of a period of hospital confinement. PAT is covered when referred by the Attending Physician and is rendered within seven (7) days of the scheduled Hospital confinement. PAT will still be covered if the scheduled confinement is postponed due to PAT showing there is another condition that must be treated prior to admission, a medical condition develops that forces postponement of the planned hospitalization, a hospital bed is not available when originally scheduled, or PAT indicates that confinement is not necessary contrary to expectations.

Diagnostic Laboratory Benefit
This Plan will consider Medically Necessary Eligible Expenses for diagnostic laboratory services as shown in the Schedule of Benefits.

Diagnostic X-ray and Testing Benefit
This Plan will consider Medically Necessary Eligible Expenses for diagnostic x-ray and other diagnostic testing as shown in the Schedule of Benefits.

CAT Scan, MRI and/or PET Scan Benefit
This Plan will consider Medically Necessary Eligible Expenses for CAT Scan, MRI and PET Scan services as shown in the Schedule of Benefits.

Home Health Care
If a Covered Person requires skilled nursing care on an at-home basis, this Plan will consider the following expenses as shown on the Schedule of Benefits when referred by the Attending Physician:

1. Part-time or intermittent nursing care by an R.N., L.P.N., or L.V.N., or Home Health Aide when such aide is providing care of a medical or therapeutic nature;
2. Physical, Occupational or Speech Therapy;
3. Medical Social Work and Nutrition Services;
4. Medical supplies, appliances, equipment, drugs and medicines that can only be obtained upon written prescription of a Physician; and
5. Home visits by the Attending Physician.

Nursing services which do not require the skills of an R.N., L.P.N. or L.V.N. and custodial care are not covered expenses. One visit is a rendered service up to four hours in length. Medically Necessary service visits exceeding four hours will count as more than one visit with each four hour segment counting as a visit against the visit limitations that may apply.

MEDICAL BENEFITS

Hospice Care

When, by reason of Injury or Illness, a Physician certifies that a Covered Person is terminally ill and Eligible Hospice Care Expenses are incurred, this Plan will pay consider the following expense as shown on the Schedule of Benefits.

Eligible Hospice Care Expenses are the UCR charges made by a Hospice for the following services or supplies:

(a) charges for inpatient care;
(b) charges for drugs and medicines;
(c) charges for part-time nursing by an RN, LPN or LVN;
(d) charges for Physical and respiratory therapy in the home;
(e) charges for the use of medical equipment;
(f) charges for visits by licensed or trained social workers, psychologists or counselors.

Physician Services

This Plan will consider the charges of a Physician in connection with a Covered Treatment or service as shown in the Schedule of Benefits, but not for more visits or Treatments than those found elsewhere in this document that limit payment for a particular condition or Treatment. This means that where a service is limited to a certain amount of days, dollars or visits, the same limit on days, dollars or visits also applies to Physician visits. If the services of, or consultation with, a Physician other than the Covered Person's own is required, this Plan will consider those charges, but not for observation, reassurance, or standby services. Services which are unbundled will be denied or limited to the reasonable and customary allowance for the most appropriate procedure code as determined by this Plan.

The maximum eligible charge for medically indicated Assistant Surgeon services will not exceed 25% of the allowance for the primary surgeon.

Rehabilitative Services/Habilitative Services

Physical, Occupational, Speech Therapy and Cognitive Rehabilitation

This Plan will consider Medically Necessary short-term therapy services when referred by the Attending Physician up to the applicable maximum as shown on the Schedule of Benefits. Therapy services include:

1. Occupational therapy
2. Physical Therapy;
3. Cardiac Therapy;
4. Respiratory Therapy;
5. Speech Therapy;
6. Acupuncture; and
7. Urinary incontinence therapy.

Rehabilitative Services/Habilitative Services
Physical, Occupational, Speech Therapy and Cognitive Rehabilitation (continued)
Exercise equipment, pillows, supports, and other supplies and materials are excluded. Rehabilitation services are limited to short term treatment for conditions which will result in significant improvement based on the Treatment plan prescribed. Long-term therapy (therapy provided for more than the maximum number of visits per Illness or Injury in a Plan Year as shown on the Schedule of Benefits) and therapy services for chronic problems or routine maintenance (to prevent deterioration of function, such as stretching, massage, and range of motion exercises) are excluded from coverage. General exercises, maintenance exercise programs, physical conditioning programs, electrical nerve stimulation, help with activities of daily living and any therapy services that are determined not Medically Necessary are not covered under this Plan.

Physical, occupational and speech therapy are not covered for learning disabilities, developmental delay, communication delay, perceptual disorder, mental retardation or related conditions, behavior disorders, multiple handicaps, sensory deficit and motor dysfunction. Neuro-educational testing, treatment and special therapies related to the listed conditions are not covered.

Chiropractic Care & Spinal Manipulation
This Plan will consider the Medically Necessary Eligible Expenses for services rendered by a physician including, but not limited to, examination, x-ray, manipulation and other therapeutic modalities, as shown on the Schedule of Benefits. Exercise equipment, pillows, supports and other supplies and materials are excluded. Long-term therapy and therapy services for chronic problems or routine maintenance (to prevent deterioration of function, such as stretching, massage, and range of motion exercises) are excluded from coverage. General exercises, maintenance exercise programs, physical conditioning programs, electrical nerve stimulation and any therapy services that are determined not Medically Necessary are not covered under this Plan.

Well Child Care and Child Immunizations
For Covered Dependent Children from birth to age 18, this Plan will consider charges for routine physical health examinations (except when required by a third party), immunizations, and screening laboratory, testing and x-ray as shown on the Schedule of Benefits.

Preventive Care
For Covered Students and Covered Spouses/Domestic Partners, Preventive Care and related screening tests as shown on the Schedule of Benefits.

For Covered Dependent Children age 18 and over, this Plan will consider charges for Preventive Care and related screening tests as shown on the Schedule of Benefits.

MEDICAL BENEFITS

Pediatric Vision Care Expense

If a Covered Person under age 19 incurs Eligible Expenses for a service included in the list of Eligible Expenses below and the service is performed or prescribed by an optometrist or other Physician, benefits will be paid as shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is covered under this Plan.

Eligible Expenses include the following:

(a) charges made for vision examination by an optometrist or ophthalmologist, including
   1. one routine eye examination every Plan Year;
   2. one pair of standard eyeglass lenses or contact lenses every Plan Year;
   3. one frame every Plan Year;

(b) diagnostic services – one eye (ophthalmologic) exam covered in full every Plan Year, including dilation (refraction);

LENSES – one pair every Plan Year. Prescription glasses or contacts may be selected as follows:

1. single vision - conventional (lined) bifocal or trifocal;
2. Lenticular – may be plastic
   (a) lenses may be glass or plastic, all lens power (single, bifocal, trifocal, Lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses;
      (ii) polycarbonate lenses covered in full for children;
      (iii) all lenses include scratch resistant coating with no additional copayment

FRAMES – one frame per Policy Year

CONTACT LENSES –one pair every Policy Year in lieu of eyeglasses.
Benefit will be paid for Medically Necessary contact lenses for treatment of Covered Persons affected by certain conditions: Karatoconus, pathological myopia, aphakia, anisometropia, aneseikonia, aniridia, corneal disorders, post-traumatic disorders, irregular astigmatism. Contact lenses are Medically Necessary when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression.

(c) Low vision – low vision is a significant loss of vision but not total blindness. This benefit covers evaluation and prescription of optical devices by ophthalmologist and optometrist. This benefit covers one comprehensive low vision evaluation every 5 years with low vision aid allowance for items such as high-power spectacles, magnifiers and telescopes, and follow-up care 4 visits in any 5 year period.

No benefits will be payable for charges incurred for:

(1) orthoptics or vision training and any supplemental texting, plano (non-prescription) lenses; or two pair of eyeglasses in lieu of bifocal or trifocals;
(2) medical or surgical treatment of the eyes;
(3) safety eyewear;
(4) spectacle lens styles, materials, treatment, or “add-ons” not shown in the Schedule of Benefits.

MEDICAL BENEFITS

Pediatric Dental Treatment

When a Covered Person under age 19 incurs Eligible Dental Expenses for dental treatment during the Plan Year, this Plan will pay the UCR charges for Eligible Dental Expense incurred in connection with covered dental treatment based on the Schedule of Covered Dental Services below. The Eligible Dental Expense must be incurred while the Covered Person is insured for these benefits.

Eligible Dental Expense means charges by a dentist, other Physician or dental hygienist acting within the scope of such person's license that is:

(a) a dental procedure listed in the Schedule of Covered Dental Charges;
(b) customarily used for treatment of the dental condition; and
(c) done according to accepted standards of dental practice.

No benefits will be payable for charges incurred for:

1. charges for a dental service or procedure in excess of the UCR charge;
2. overdentures and associated procedures;
3. cosmetic procedures;
4. implants, removal of implants, the replacement of lost or stolen appliances, the replacement of orthodontic retainers, athletic mouthguards, precision or semi-precision attachments, denture duplication, overdentures and any associated surgery, or other customized services or attachments and related procedures, or sealants;
5. oral hygiene instructions, plaque control, the completion of a claim form, acid etch, broken appointments, prescription of take-home fluoride, or diagnostic photographs;
6. services not completed by the end of the month in which insurance terminates;
7. treatment by an immediate family member;
8. appliances, services or procedures relating to: (i) the change or maintenance of vertical dimensions; (ii) restoration of occlusion; (iii) splinting; (iv) correction of attrition, abrasion, erosion or a fraction; (v) bite regulation; or (vi) bite analysis.

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES

BASIC SERVICES:
Diagnostic and Treatment Services
D0120 Periodic oral evaluation - Limited to 1 every 6 months
D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
D0150 Comprehensive oral evaluation - Limited to 1 every 6 months
D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months
D0210 Intraoral – complete series (including bitewings) 1 every 60 (sixty) months
D0220 Intraoral - periapical first film
D0230 Intraoral - periapical - each additional film
D0240 Intraoral - occlusal film
D0270 Bitewing - single film -1 set every 6 months

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

BASIC SERVICES (continued):
Diagnostic and Treatment Services (continued)
D0272 Bitewings - two films - 1 set every 6 months
D0274 Bitewings - four films - 1 set every 6 months
D0277 Vertical bitewings – 7 to 8 films – 1 set every 6 months
D0330 Panoramic film – 1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral / Facial Photographic Images
D0470 Diagnostic Models
D00460 Pulp Vitality Tests
Preventative Services
D1120 Prophylaxis – Child - Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) – Age 15 to 19 - 2 every 12 months
D1206 Topical fluoride varnish - 2 in 12 months
D1351 Sealant - per tooth - unrestored permanent molars - 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every36 months.
D1510 Space maintainer – fixed – unilateral
D1515 Space maintainer – fixed – bilateral
D1520 Space maintainer - removable – unilateral
D1525 Space maintainer - removable – bilateral
D1550 Re-cementation of space maintainer
D7285 Incisional Biopsy of Oral Tissue- hard (bone, tooth)
D7286 Incisional biopsy or oral tissue- soft
Additional Procedures covered as Basic Services
D9110 Palliative treatment of dental pain – minor procedure

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

INTERMEDIATE SERVICES:
Minor Restorative Services
D2140 Amalgam - one surface, primary or permanent
D2150 Amalgam - two surfaces, primary or permanent
D2160 Amalgam - three surfaces, primary or permanent
D2161 Amalgam - four or more surfaces, primary or permanent
D2330 Resin–based composite - one surface, anterior
D2331 Resin-based composite - two surfaces, anterior
D2332 Resin-based composite - three surfaces, anterior
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior)
D2910 Re-cement inlay
D2920 Re-cement crown
D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
D2940 Protective Restoration
D2951 Pin retention - per tooth, in addition to restoration
Endodontic Services
D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

INTERMEDIATE SERVICES (continued):
Periodontal Services
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy
Prosthodontic Services
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture – mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5610 Repair resin denture base
D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

INTERMEDIATE SERVICES (continued):
Prosthodontic Services (continued)
D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report
Oral Surgery
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

INTERMEDIATE SERVICES (continued):
Oral Surgery (continued)
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingival

MAJOR SERVICES:
Major Restorative Services
D0160 Detailed and extensive oral evaluation - problem focused, by report
D2510 Inlay - metallic – one surface – An alternate benefit will be provided
D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided
D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided
D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

MAJOR SERVICES (continued):
Major Restorative Services (continued)
D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
D2790 Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal– Limited to 1 per tooth every 60 months
D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months
D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months
D2980 Crown repair, by report
Endodontic Services
D3310 Anterior root canal (excluding final restoration)
D3320 Bicuspid root canal (excluding final restoration)
D3330 Molar root canal (excluding final restoration)
D3346 Retreatment of previous root canal therapy-anterior
D3347 Retreatment of previous root canal therapy-bicuspid
D3348 Retreatment of previous root canal therapy-molar
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)
D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
D3410 Apicoectomy/periradicular surgery - anterior
D3421 Apicoectomy/periradicular surgery - bicuspid (first root)
D3425 Apicoectomy/periradicular surgery - molar (first root)
D3426 Apicoectomy/periradicular surgery (each additional root)

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

MAJOR SERVICES (continued):
Endodontic Services (continued)
D3450 Root amputation - per root
D3920 Hemisection (including any root removal) - not including root canal therapy
Periodontal Services
D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
D4211 Gingivectomy or gingivoplasty – one to three teeth
D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months
D4249 Clinical crown lengthening-hard tissue
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
D4270 Pedicle soft tissue graft procedure
D4271 Free soft tissue graft procedure (including donor site surgery)
D4273 Subepithelial connective tissue graft procedures (including donor site surgery)
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime
Prosthodontic Services
D5110 Complete denture - maxillary – Limited to 1 every 60 months
D5120 Complete denture - mandibular – Limited to 1 every 60 months
D5130 Immediate denture - maxillary – Limited to 1 every 60 months
D5140 Immediate denture - mandibular – Limited to 1 every 60 months
D5211 Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
D6010 Endosteal Implant - 1 every 60 months
D6012 Surgical Placement of Interim Implant Body - 1 every 60 months
D6040 Eposteal Implant – 1 every 60 months
D6050 Transosteal Implant, Including Hardware – 1 every 60 months

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

MAJOR SERVICES (continued):
Prosthodontic Services (continued)
D6055 Connecting Bar – implant or abutment supported - 1 every 60 months
D6056 Prefabricated Abutment – 1 every 60 months
D6058 Abutment supported porcelain ceramic crown -1 every 60 months
D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months D6074 Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
D6074 Abutment supported retainer for cast noble metal fixed partial denture – 1 every 60 months
D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months
D6080 Implant Maintenance Procedures -1 every 60 months
D6090 Repair Implant Prosthesis -1 every 60 months

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

MAJOR SERVICES (continued):
Prosthodontic Services (continued)
D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months
D6095 Repair Implant Abutment -1 every 60 months
D6100 Implant Removal -1 every 60 months
D6190 Implant Index -1 every 60 months
D6210 Pontic - cast high noble metal – Limited to 1 every 60 months
D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months
D6212 Pontic - cast noble metal– Limited to 1 every 60 months
D6214 Pontic – titanium – Limited to 1 every 60 months
D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
D6241 Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months
D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months
D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months
D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
D6543 Onlay – metallic – three surfaces - 1 every 60 months
D6544 Onlay – metallic – four or more surfaces -1 every 60 months
D6545 Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
D6740 Crown - porcelain/ceramic -1 every 60 months
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months
D6752 Crown - porcelain fused to noble metal - 1 every 60 months
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months

Pediatric Dental Treatment (continued)

SCHEDULE OF COVERED PEDIATRIC DENTAL SERVICES (continued)

MAJOR SERVICES (continued):
Prosthodontic Services (continued)
D6782 Crown - 3/4 cast noble metal - 1 every 60 months
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months
D6790 Crown - full cast high noble metal - 1 every 60 months
D6791 Crown - full cast predominately base metal - 1 every 60 months
D6792 Crown - full cast noble metal - 1 every 60 months
D6973 Core buildup for retainer, including any pins - 1 every 60 months
D9940 Occlusal guard, by report - 1 in 12 months for patients 13 and older

ORTHODONTIC SERVICES:
Orthodontic Services
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy
D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
Anesthesia Services
D9220 Deep sedation/general anesthesia – first 30 minutes
D9221 Deep sedation/general anesthesia – each additional 15 minutes
Intravenous sedation
D9241 Intravenous conscious sedation/analgesia – first 30 minutes
D9242 Intravenous conscious sedation/analgesia – each additional 15 minutes

MEDICAL BENEFITS

Pap Smear
Routine pap smear is limited to one per Plan Year for women ages 18 and older. Covered Students/Spouses/Partners must obtain this service from UHS.

Screening Mammography
This Plan will consider one baseline mammogram for Covered Persons between the age of 35 and 40, one mammogram every two years for persons between the ages of 40 and 50, and once annually thereafter.

For those with a personal or family history of breast cancer or biopsy proven benign breast disease, or having a first child after the age of 30, a mammography may be covered more often based upon a Physician's recommendation.

Mental Health and Chemical Dependency Treatment
This Plan will cover treatment for organic and non-organic mental health and chemical dependency conditions on the same basis as any other illness as shown on the Schedule of Benefits. Inpatient hospital and physician expenses may be limited as shown on the Schedule of Benefits and exclude: (1) charges for personal and convenience items, (2) charges made by an art, music or recreational therapist, and (3) charges for family or marital counseling. Expenses for Medically Necessary partial hospitalization are processed as described. Outpatient treatment consists of outpatient, out-of-hospital (office), and Emergency Room treatment and is limited to the specified maximums as shown on the Schedule of Benefits. Family or marital therapy, and, art, music or recreational therapy are excluded. Covered professional providers include Ed.D., Ph.D., D.O., M.D. and licensed therapists in Social Work and Psychology.

Diabetic Supplies and Education
This Plan covers diabetic supplies and materials (blood glucose monitor, monitor supplies, testing strips, lancets). Insulin, insulin needles, testing strips, lancets and anti-diabetic agents are covered through the Outpatient Prescription Drug Benefit. Diabetic education and counseling are also a covered service under this Plan. Separate fees for education and counseling materials, such as books and pamphlets, are excluded.

Ambulance Services
Medically Necessary ambulance and air transport services when required in connection with a life threatening medical emergency to the nearest hospital facility. Medically Necessary ambulance and air transport from one hospital facility to another when the originating facility is not equipped to Treat the Covered Person's Illness or Injury will also be considered a Covered Service. Transportation for the convenience of the patient or the patient's family, including but not limited to, attending medical appointments or obtaining required diagnostic services or other procedures, is excluded by this Plan.

Private Duty Nursing
If a Covered Person requires the services of a Registered Nurse (R.N.) or licensed practical nurse (L.P.N.) under the direction of the Attending Physician, this Plan will reimburse Eligible Expenses as shown on the Schedule of Benefits. Care that is mainly custodial in nature is excluded by this Plan.

Extraction of Natural Teeth and Replacement with Artificial Teeth Because of Accidental Injury
Total extraction and total replacement (limited to bridge or denture) of sound natural teeth when necessitated by a covered injury. Crowns or caps for broken teeth, in lieu of extraction and replacement, may be considered if approved by this Plan before the service is performed. Injuries caused by chewing, biting, or piercings are not considered to be accidental injuries under this Plan.

Other Covered Services
The following services, when (1) performed in accordance with a Covered Illness or Injury, (2) Medically Necessary for the Treatment of a Covered Illness or Injury, and (3) not otherwise excluded by this Plan, will be covered as shown on the Schedule of Medical Benefits:

1. Allergy testing and treatment;

2. Chemotherapy with federally approved chemotherapy drugs, the administration of these drugs and all associated laboratory tests and procedures, and radiation therapy and all associated laboratory tests and procedures;

3. Injectable medications for the treatment of a Covered Illness or Injury administered by a Physician in his or her office;

4. Services of a nurse midwife are covered when provided within the scope of the nurse midwife license (services by a doula are not covered by this Plan);

5. Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Physician are covered under the Outpatient Prescription Drug Benefit;

6. Obstetrical care including pre and post natal care, complications of pregnancy and childbirth will be considered under this Plan on the same basis as any other Illness. Childbirth preparation classes and sibling classes are excluded by this Plan. If the Treating Physician, in consultation with the mother, discharges the mother and newborn prior to 48 hours following a normal vaginal delivery, or prior to 96 hours following a normal cesarean delivery, the Covered Student or Spouse shall be entitled to one home health visit within 48 hours after discharge. Pre and post-natal care, complications of pregnancy and childbirth are considered by this Plan according to the global fee for delivery;

Other Covered Services, (continued)

7. Oral surgery in an outpatient setting when required in connection with the following:
   a. An Accidental Injury to the jaw or structures contiguous to the jaw, including Accidental Injury to the teeth, which occurs while a Covered Person and provided that care or Treatment is sought within 24 hours, or as soon as practical thereafter, of the Accidental Injury. Benefits for extraction and replacement of non-restorable natural teeth damaged due to a covered Injury to the teeth or jaw are payable. Accidental Injury resulting from chewing or biting or injuries resulting from dental disease are excluded;
   b. The correction of a non-dental physiological condition which has resulted in severe functional impairment;
   c. Treatment for tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of mouth;
   d. Surgical removal of full or partial bony impacted wisdom teeth, except that the initial visit and x-rays to determine impaction are excluded;
   e. Removal of the apex of tooth root, root removal or root amputation;
   f. Frenectomy;
   g. Cutting of accessory sinuses, salivary glands or ducts;

8. Cardiac Rehabilitation, respiratory therapy and urinary incontinence therapy, provided that such services are Medically Necessary, referred by a Physician, performed by a licensed provider acting within the scope of such license. Therapy services for chronic problems or routine maintenance for chronic conditions are excluded;

9. Anesthesia services when performed by an anesthesiologist in connection with a Covered Service, including expenses for anesthesia made by a Certified Registered Nurse Anesthetist (CRNA), but not charges made by both an anesthesiologist and a CRNA for the same procedure. In circumstances where a charge is made by both an anesthesiologist and a CRNA for the same procedure, this Plan will consider the lesser charge as the Eligible Expense;

10. Mastectomy Provision: if a Covered Person undergoes a mastectomy, this Plan will also cover charges for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and provide benefits for prostheses and physical complications of all stages of mastectomy, including lymphedemas. The breast reconstruction benefit applies only to Covered Persons in the manner determined in consultation with the attending physician and patient.. Preventive mastectomy, along with any resultant Treatment and reconstruction, is excluded;

Other Covered Services, (continued)

11. Durable medical equipment if deemed Medically Necessary, is primarily and customarily used for medical purposes and is not generally useful in the absence of Illness or Injury, can effectively be used outside of a medical facility, can be expected to make a significant contribution to the Treatment of Illness or Injury, and is used solely for the care and Treatment of the Covered Person. This Plan will pay rental up to the purchase price. Durable medical equipment consists of, but is not restricted to, the initial fitting and rental to purchase price (this Plan reserves the right to purchase equipment outright on a case-by-case basis) of braces, trusses, crutches, renal dialysis equipment, ostomy and urological supplies, including but not limited to colostomy bags and ureterostomy bags, hospital-type beds, traction equipment, wheelchairs and walkers. The following items are not considered to be durable medical equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators, stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths and other equipment which has both a non-therapeutic and therapeutic use;

12. The initial contact lenses or eyeglasses required immediately following cataract surgery performed while a Covered Person are payable at 90% In-Network and 60% after deductible for Non-Network;

13. Charges related to expenses incurred in the therapeutic treatment of Inherited Metabolic Diseases, including the purchase of medical foods (food that is intended for dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered internally under direction of a Physician) and low protein modified food products (specially formulated to have less than one (1) gram of protein per serving and is intended to be used under the direct supervision of a Physician and excludes any natural food that is naturally low in protein), when diagnosed and determined to be Medically Necessary by the Covered Person's Physician;

14. Treatment of growth retardation, including prescription drugs, is covered only when production of the growth hormone is absent due to pituitary gland loss or failure. Eligible expenses are reimbursed at 90% In-Network and 60% after deductible for Non-Network services. There is no coverage for short stature syndrome or other related growth abnormalities;

15. The initial purchase, fitting, repair and replacement of fitted prosthetic devices which replace body parts when required for a covered Illness or Injury sustained while a Covered Person;

16. Treatment for Temporomandibular Joint Disorder to include diagnostic procedures and Medically Necessary surgical or non-surgical (intraoral splint therapy devices) treatment if the condition is caused by congenital, developmental or acquired deformity, disease or Injury and the procedure or device is reasonable and appropriate for the diagnosis or treatment of the condition. Cosmetic or elective orthodontic care, periodontic care or general dental care is excluded by this Plan;

Other Covered Services, (continued)

17. Dental anesthesia: Benefits are payable for Eligible Expenses incurred for a Hospital or Ambulatory Surgery Center incurred, and anesthetics provided, in conjunction with dental care provided to a Covered Person in a Hospital or Ambulatory Surgery Center if any of the following apply:
    a. The Covered Person is a Dependent child under the age of five (5),
    b. The Covered Person has a chronic disability that meets all the conditions under Wisconsin law,
    c. The Covered Person has a medical condition that requires hospitalization or general anesthesia for dental care.

18. Autism Spectrum Disorder: Benefits are payable for Eligible Expenses incurred by a Covered Person for the treatment for autism spectrum disorder if the treatment is prescribed by a Physician and provided by any of the following who are qualified to provide intensive-level services or non-intensive-level services:
    a. A psychiatrist;
    b. A person who practices psychology;
    c. A social worker, who is certified or licensed to practice psychotherapy;
    d. A licensed behavior analyst;
    e. A paraprofessional working under the supervision of a provider listed under a, b, c or d above;
    f. A professional working under the supervision of a certified outpatient mental health clinic;
    g. A speech-language pathologist;
    h. An occupational therapist.

    Benefits will provide for at least $100,000 for intensive-level services per Covered Person per Plan Year, with a minimum of 30 to 35 hours of care per week for a minimum duration of 4 years, and at least $100,000 for non-intensive-level services per Covered Person per Plan Year. The minimum coverage monetary amounts or duration required for treatment need not be met if it is determined by a supervising professional, in consultation with the Covered Person's Physician, that less treatment is medically appropriate.

    "Autism spectrum disorder" means any of the following: (a) autism disorder; (b) asperger's syndrome; or (c) pervasive developmental disorder not otherwise specified.

    "Intensive-level services" means evidence-based behavioral therapy that is designed to help an individual with autism spectrum disorder overcome the cognitive, social, and behavioral deficits associated with that disorder.

    "Non-intensive-level services" means evidence-based therapy that occurs after the completion of treatment with intensive-level services and that is designed to sustain and maximize gains made during treatment with intensive-level services or, for an individual who has not and will not receive intensive-level services, evidence-based therapy that will improve the individual's condition.

    The Plan will pay the benefits on the same basis as any other Illness as shown on the Schedule of Benefits.

Other Covered Services, (continued)

19. Hearing aid, cochlear implants and related treatments: For a Covered Person age 18 and older who is certified as deaf or hearing impaired by a Physician or an audiologist licensed under Wisconsin law, benefits are payable for Eligible Expenses incurred for the cost of hearing aids and cochlear implants that are prescribed by a Physician, or by an audiologist licensed under Wisconsin law, in accordance with accepted professional medical or audiological standards. Benefits are limited to a single purchase (including repair/replacement) every three years.

    For a Covered Dependent child who is under 18 years of age and who is certified as deaf or hearing impaired by a Physician or an audiologist licensed under Wisconsin law, benefits are payable for Eligible Expenses incurred for the cost of hearing aids and cochlear implants that are prescribed by a Physician, or by an audiologist licensed under Wisconsin law, in accordance with accepted professional medical or audiological standards. Benefits are also payable for Eligible Expenses incurred for the cost of treatment related to hearing aids and cochlear implants, including procedures for the implantation of cochlear devices. Benefits will not exceed the cost of one hearing aid per ear per child more than once every three years.

    The Plan will pay the benefits on the same basis as any other Injury or Illness as shown on the Schedule of Benefits.

20. Colorectal Cancer Screening: Benefits are payable for Eligible Expenses incurred for colorectal cancer screening. The charges must be incurred while the Covered Person is insured for these benefits.

Eligible Expenses include the following:

(a) for persons 50 years of age or older:
    (1) screening with annual fecal occult blood tests (3 specimens);
    (2) flexible sigmoidoscopy every 5 years;
    (3) colonoscopy every 10 years;
    (4) double contrast barium enema every 5 years; or
    (5) any combination of the most reliable, medically recognized screening tests available as may be determined by the Secretary of Health and Social Services of the State.

(b) for persons under 50 who are deemed at high risk for colon cancer because of:
    (1) family history of familial adenomatous polyposis;
    (2) family history of hereditary nonpolyposis colon cancer;
    (3) chronic inflammatory bowel disease;
    (4) family history of breast, ovarian, endometrial, colon cancer or polyps; or
    (5) a background, ethnic or lifestyle such that the Physician treating the Covered Person believes he or she is at elevated risk.

Other Covered Services, (continued)

In the case of item (b) above, screening by colonoscopy, barium enema or any combination of the most reliable, medically recognized screening tests available as determined by the Secretary of Health and Social Services of the State shall be covered at a frequency determined by the Physician.

The Plan will pay the benefits on the same basis as any other Illness as shown on the Schedule of Benefits.

21. Clinical Trials Expense: Benefits are payable for the routine patient costs incurred by a Covered Person who participates in a Phase I, Phase II, Phase III, or Phase IV that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. Eligible Expenses under this coverage will be paid on the same basis as any other Illness. The Eligible Expenses must be incurred while a Covered Person is covered under this Plan.

    For purposes of this benefit "approved clinical trial" includes:

    (a) federally funded trials – the study or investigation is approved or funded (which may include funding through in-kind contributions) by one of the following:
        (1) the National Institutes of Health (NIH);
        (2) the Centers for Disease Control and Prevention;
        (3) the Agency for Health Care Research and Quality;
        (4) the Centers for Medicare & Medicaid Services;
        (5) cooperative group or center of any of the entities described in items (1) through (4) above or the Department of Defense or the Department of Veterans Affairs;
        (6) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; and
        (7) any of the following if: a) the Secretary of HHS deemed that its system of peer review is comparable to that of NIH; and b) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
            1. The Department of Veterans Affairs;
            2. The Department of Defense; and
            3. The Department of Energy.
    (b) the study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
    (c) the study or investigation is a drug trial that is exempt from having such an investigational new drug application; and
    (d) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.

    "Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including:

    (a) the National Cancer Institute Clinical Cooperative Group;
    (b) the National Cancer Institute Community Clinical Oncology Program;
    (c) the AIDS Clinical Trials Group and
    (d) the Community Programs for Clinical Research in AIDS.

Other Covered Services, (continued)

"FDA" means the federal Food and Drug Administration.

"Life-threatening condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

"Routine patient cost" means the cost of a Medically Necessary health care service that is incurred as a result of the treatment being provided to the Covered Person for purposes of the clinical trial. Patient Cost includes charges incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the Covered Person's particular condition, to the extent that the drugs or devices are not paid by the manufacturer, distributor or provider of that drug or device. Routine patient cost does not include any of the following charges:

(a) the cost of an investigational item, device, or service itself;
(b) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
(c) services that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Eligible Expenses under this coverage will be paid on the same basis as any other Illness.

22. Drugs for Treatment of HIV Infection: Benefits are payable for Eligible Expenses incurred for prescription drugs for the treatment of HIV infection. The Plan will pay benefits on the same basis as for any other Illness. Benefits will not be denied based on a Medical Necessity requirement except for reasons that are unrelated to the legal status of the drug.

    The drug must be:
    (1) prescribed by the Covered Person's Physician for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infection;
    (2) approved by the federal Food and Drug Administration for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infection, including each investigational new drug that is approved pursuant to federal law for the treatment of HIV infection or an Illness or medical condition arising from or related to HIV infection and that is in, or has completed, a phase 3 clinical investigation performed in accordance with federal requirements; and
    (3) prescribed and administered in accordance with the treatment protocol approved for the drug if it is an investigational drug.

23. Lead Screening: Benefits are payable for Eligible Expenses incurred by a covered Dependent child for lead poisoning screening. The Eligible Expenses must be incurred while the Dependent child is insured for these benefits. The Plan will pay the Eligible Expenses incurred on the same basis of any other Illness.
    Covered Expenses include lead poisoning screening test for children under the age of six years which shall be conducted in accordance with any recommended lead screening methods and intervals contained in any rules promulgated by the Wisconsin Department of Health and Family Services under Statute 254.158.

MEDICAL BENEFITS

Prescription Drug Benefit

Plan participants will utilize the SHIP Membership card to obtain Covered prescription medications at a network retail pharmacy. Refer to the Schedule of Benefits for copayments and benefits. The prescription program is based upon a formulary of medications. Contact CVS Caremark Customer Care at 1-866-818-6911 to obtain information regarding the formulary in use by the Plan.

Prescription Benefits are based on a mandatory generic CVS Caremark formulary, which means that CVS Caremark participating pharmacies will fill generic prescriptions on all covered formulary medications if there is a generic drug available. If generic drugs are available and not listed on the formulary, but the brand name drug is, the generic drugs are preferred at the generic copayment. Prior authorization is required if the Covered Person's Physician requests a brand-name drug because of medical necessity when a generic drug is available. If the request is authorized, the Covered Person will pay the non-formulary (Tier 3) copayment. If the Covered Person is requesting brand name when generic is available, and it is not Medically Necessary, a brand name copayment (Tier 2) plus the difference in cost between brand and generic will apply.

Medications include:

1. Federal Legend Drugs,
2. Compound Medications (which include at least one Federal Legend Drug in a therapeutic amount),
3.
4. Blood Glucose Monitors (free through customer care)
   *Members with diabetes who have a valid prescription for OneTouch or Accu-chek blood glucose test strips may contact the CVS Caremark diabetic meter team at 1-877-417-4746 to obtain a OneTouch or Accu-chek blood glucose meter at no cost.

Excluded Medications and Supplies include:

- Over-the-counter products or equivalents (unless specifically listed in the CVS Caremark formulary) and state restricted drugs,
- Therapeutic devices or appliances, except diabetic supplies,
- Immunization agents, biological serum, blood products, vaccines, except most preventive vaccines
- Implantable time-released medication, except implantable contraceptives, unless otherwise noted,
- Experimental or investigational drugs or drugs prescribed for experimental indications,
- Cosmetic drugs and agents except Retin A as described in the CVS Caremark formulary,
- Impotence medications, except for the treatment of Benign Prostatic Hyperplasia (requires prior authorization),
- Nutritional supplements unless otherwise noted,
- Fertility enhancing medications,
- Weight loss medications (unless deemed medically necessary after prior authorization),
- Legend Vitamins,
- Dental products except fluoride tablets and drops as described in CVS Caremark formulary,
- Injectable delivery devices and syringes for uses other than for insulin.

MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

This Plan does not cover nor provide benefits for:

1. Expense incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth or for extraction of impacted wisdom teeth or as specifically provided elsewhere in this Plan. This includes, but is not limited to: dental implants; shortening of the mandible or maxillae; correction of malocclusion; and hospitalization costs for services not specifically listed in the Benefits Section. (Note: Under some circumstances, mandated TMJ benefits under Wis. Stat. § 632.895 (11) may supercede this benefit).
2. Expense incurred for services normally provided without charge by the University's Health Service, Infirmary or Hospital, or by health care providers employed by the University. Some exceptions apply. See **Waiver of Primary Preventive Care Provider Requirements** on page 15.
3. Expense incurred for eyeglasses, contact lenses, hearing aids, or prescriptions or examinations for such except as required for repair caused by a covered Injury, immediately following cataract surgery that was performed while a Covered Person, or as specifically provided elsewhere in this Plan.
4. Expense incurred as a result of Injury due to participation in a riot.
5. Expense incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.
6. Expense incurred for Injury or Illness resulting from declared or undeclared war or any act thereof.
7. Expense incurred as a result of an Injury or Illness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
8. Expense incurred as a result of Injury sustained or Illness contracted while in the service of the Armed Forces of any country.
9. Expense incurred for treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. Expense incurred for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a Covered Dependent child which has resulted in a functional defect; or breast reconstructive surgery after a mastectomy.
11. Expense for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.
12. Expense incurred for preventive medicines, serums, or vaccines except as specifically provided in this Plan or at UHS.
13. Expense incurred as a result of participation in a felony.
14. Expense incurred after the date coverage terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

15. Expense incurred for any services rendered by a member of the Covered Person's immediate family.
16. Expense incurred for a treatment, service or supply which is not Medically Necessary.
17. Expense for outpatient prescriptions except as specifically provided in this Plan.
18. Expense for artificial insemination, invitro fertilization, gamete or zygote intrafallopian transfer, or reversal of voluntary sterilization.
19. Expense for the treatment of obesity, including, but not limited to the following: weight reduction or dietary control programs, prescription (except prescriptions deemed medically necessary after prior authorization) or nonprescription drugs or medications such as vitamins (whether taken orally or by injection), minerals, appetite suppressants, or nutritional supplements and any complication resulting from weight loss treatments or procedures; or surgical treatment of obesity and any complications therefrom.
20. Expense for routine physical examinations and routine testing except as specifically provided in this Plan.
21. Abortion expenses.

APPEALS OF ADVERSE BENEFITS DETERMINATIONS

- **Full and Fair Review of All Claims**
  In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination.

- **Requirements of Appeals**
  The claimant must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the claimant's appeal must be addressed as follows:
  Wellfleet Group, Appeals Department, P.O.Box 15369, Springfield, MA 01115.

  It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of this Plan. Any appeal must include:

1. The name of the covered person/claimant;
2. The covered person/claimant's Member number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise facts and theories that support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under this Plan.

- **Timing of Notification of Benefit Determination on First Appeal**
  The Third Party Administrator shall notify the claimant of the Plan's benefit determination on review within the following timeframe:

  Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

- **Manner and Content of Notification of Adverse Benefit Determination on Appeal.**
  The Third Party Administrator shall provide a claimant with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of this *Plan* on which the denial is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
4. If the adverse benefit determination is based upon a medical judgment, an explanation of the scientific or clinical judgment for the determination;
5. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary.

APPEALS OF ADVERSE BENEFITS DETERMINATIONS

EXTERNAL APPEALS

The Plan provides for review of adverse decisions by an external, independent review organization (IRO). The Covered Person or someone authorized to represent the Covered Person may request an external review. Wellfleet will notify the Covered Person in writing of his or her right to request an external review each time the Covered Person:

(a) receives a notification decision, or
(b) receives an appeal decision upholding an adverse decision.

In order for your request to be eligible for external review, Wellfleet must determine the following:

(a) the Covered Person's request is about a Medical Necessity determination that resulted in an adverse decision;
(b) the Covered Person had coverage with the Plan in effect when the adverse decision was issued;
(c) the service for which the adverse was issued appears to be a covered service under the Plan; and
(d) the Covered Person has exhausted the Plan's internal review process.

For an external review, the Covered Person will be considered to have exhausted the internal review process if he or she has:

(a) completed the Plan's appeal and received a written determination from Wellfleet; or
(b) except to the extent that the Covered Person has requested or agreed to a delay or has not received Wellfleet's written decision within 30 days of the date the Covered Person submitted the request; or
(c) received notification that the Plan has agreed to waive the requirement to exhaust the internal appeal process; or
(d) the Third Party Administrator waives the internal appeal;
(e) urgent care situations where simultaneous expedited internal and external review may occur; and
(f) failure to comply with all requirements of internal appeals process, except in cases where the violation was:
    (i) de minimis;
    (ii) non-prejudicial;
    (iii) attributable to good cause/matters beyond the Third Party Administrator's control;
    (iv) in context of ongoing good-faith exchange of information; and,
    (v) not reflective of a pattern or practice of non-compliance.

A Covered Person may make a written, electronic or oral request of an expedited external review with the examiner at the time the Covered Person receives:

- An Adverse Determination that involves a Medical Emergency; and the Covered Person has filed a request for an expedited internal appeal; or

APPEALS OF ADVERSE BENEFITS DETERMINATIONS

- An Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility; and the Covered Person has filed a request for an expedited internal appeal; or
- A final internal Adverse Determination that involves a Medical Emergency; or
- A final internal Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility.

If the Covered Person's request for an external review is related to a retrospective adverse (an adverse which occurs after the Covered Person has received the services in question), the Covered Person will not be eligible to request a review until he or she has completed the Plan's internal review process and has received a written final determination from Wellfleet.

If the Covered Person wishes to request an external review, the Covered Person (or his or her representative) must make this request to Wellfleet within four (4) months of receiving the Plan's written notice of final determination that the services in question are not approved. When processing the Covered Person's request for external review, Wellfleet will require the Covered Person to provide a written, signed authorization for the release of any of his or her medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 5 business days of receipt of the Covered Person's request for an external review, Wellfleet will notify the Covered Person and the Covered Person's Provider of whether the request is complete and whether it is accepted. If Wellfleet notifies the Covered Person that the request is incomplete, the Covered Person must provide all requested additional information to Wellfleet within 5 business days of the date of written notice of incomplete information from Wellfleet.

(The IRO has 30 days to make a determination and will send the letter) Wellfleet will send written notice to the Covered Person of its determination within 45 days of the date they received the Covered Person's external review request. If the decision is to reverse the adverse, Wellfleet will reverse the adverse decision within 3 business days of receiving notice of decision, and provide coverage for the requested service or supply that was the subject of the adverse decision. If the Covered Person is no longer covered by the Plan at the time it receives notice of the decision to reverse the adverse, the Plan will only provide coverage for those services or supplies the Covered Person actually received or would have received prior to disenrollment if the service had not been adverse when first requested.

For further information about External Review or to request an external review, contact Wellfleet at: Wellfleet Group, P.O. Box 15369., Springfield, MA 011015.

The external review decision is binding on the Plan and the Covered Person. The Covered Person may not file a subsequent request for an external review involving the same adverse decision for which he or she has already received an external review decision.

DESCRIPTION OF ASSIST AMERICA, INC. TRAVEL ASSISTANCE SERVICES

Description of Travel Assistance Services for Students

Wherever your travels may take you, in the event of a medical emergency or unexpected travel problem, Assist America, Inc. (AAI) is never more than a phone call away. If traveling 100 miles or more from home and/or campus, AAI is the lifeline to depend on. Assist America state-of-the-art service centers deliver services 24 hours a day, 7 days a week, 365 days a year anywhere in the world.

How to contact Assist America, Inc.:
Inside the United States, dial the Assistance Center toll-free 1-877-488-9833
Outside the United States, dial the Assistance Center collect at 1-609-452-8570
When you call, 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.

A few important things to keep in mind:

- Assist America must arrange and pay for assistance services. Requests for reimbursement will not be accepted.
- Assist America does not replace your health benefit plan. Health claims are still handled by your health benefit plan.

AAI's program makes the following services available to Eligible Participants:

Medical Consultation, Evaluation and Referrals: Eligible Participants will have telephone access to operations center staffed twenty-four hours a day, every day of the year, with multilingual personnel for medical consultation, evaluation and referral to Western-trained physicians.

Emergency Medical Evacuation: When an adequate medical facility is not available proximate to the Eligible Participant, as determined by the AAI's consulting physician and the Eligible Participant's attending physician, AAI will arrange transportation under appropriate medical supervision, by an appropriate mode of transport to the nearest medical facility capable of providing the required care.

Medical Repatriation: AAI will arrange for transportation under medical supervision to the Eligible Participant's residence or to a medical or rehabilitation facility near the Eligible Participant's residence when AAI's consulting physician and the Eligible Participant's attending physician determines that transportation is medically necessary, at such time as the Eligible Participant is medically cleared for travel by AAI's consulting physician and the attending physician.

Hospital Admission Assistance: AAI shall assist in either issuing a prompt financial guarantee to facilitate admittance to a foreign (non-U.S.) medical facility and/or validate Eligible Participant's medical insurance; provided that the Eligible Participant commits in writing to repay all funds advanced for hospital admittance within forty-five (45) days of the date advanced.

DESCRIPTION OF ASSIST AMERICA, INC. TRAVEL ASSISTANCE SERVICES

Medical Monitoring: Medical personnel will monitor Eligible Participant's condition and will (i) stay in regular communication with the attending physician and/or hospital and (ii) relay necessary and legally permissible information to family members.
Prescription Assistance: If an Eligible Participant needs replacement prescription medicine while traveling, AAI helps with replacing the prescription, when possible and legally permissible and upon consulting with a treating physician; the Eligible Participant is responsible for the cost of the prescription and medicine.

Emergency Message Transmission: AAI will transmit and receive legally permitted emergency messages to and from family members and/or employer.
Compassionate Visit: When an Eligible Participant will be hospitalized for more than seven (7) consecutive days and is traveling without a companion, AAI will arrange for a family member or personal friend to travel to visit the Eligible Participant by providing an appropriate means of transportation as determined by AAI. The family member or the personal friend is responsible to meet all visa and travel document requirements, if applicable.

Care of Minor Child(ren): One-way economy common carrier transportation, with attendants if required, will be provided to the place of residence of minor child(ren) when they are left unattended as a result of medical emergency or death of an Eligible Participant.
Return of Mortal Remains: In the case of an Eligible Participant's death, AAI will arrange and pay for the return of mortal remains to an authorized funeral home proximate to the Eligible Participant's legal residence.

Emergency Trauma Counseling: Provide Eligible Participant with initial telephone-based counseling and follow-up referrals to qualified counselors as needed or requested.
Return of Vehicle: Assist America will arrange for the return of Eligible Participant's fully operable, non-commercial vehicle when necessary due to Eligible Participant's medical condition. AAI will arrange for the vehicle to be returned to the Eligible Participant's place of residence.

Interpreter and Legal Referrals: Upon request, provide referrals to interpreters, counselors or legal personnel.

Lost Luggage or Document Assistance: AAI helps Eligible Participant locate lost luggage, documents, personal belongings and assist with the replacement of travel tickets.

Bail Bond Coordination: AAI will assist in coordinating a bail bond, wherever legally permissible, as required for Eligible Participants, provided that Eligible Participant is the source of, or coordinates the source of the funds.

Emergency Cash Coordination: AAI will assist in coordinating the transfer of emergency cash for an Eligible Participant, provided Eligible Participant has a verifiable travel emergency and is circumstantially without financial means. The source of the funds is the responsibility of the Eligible Participant.

DESCRIPTION OF ASSIST AMERICA, INC. TRAVEL ASSISTANCE SERVICES

Pre-trip Information: AAI offers Participants web-based and app-based country profiles that include visa requirements, immunization and inoculation recommendations, embassy and consulate information, country-specific details and security advisories as well as other pertinent information for travel destinations.

Mobile App Services: AAI offers Mobile App services including embassy, consulate, and pharmacy locator, tap to call feature, service descriptions, electronic identification cards, and AssistAlerts.

AAI's obligation to provide or contract for the above services is subject to the following conditions/exclusions:

Conditions:

AAI will not provide services in the following instances:

- Travel undertaken specifically for securing medical treatment
- Injuries resulting from participation in acts of war or insurrection
- Commission of an unlawful act(s)
- Attempt at suicide
- Incidents involving the use of drugs unless prescribed by a physician
- Transfer of Participant from one medical facility to another medical facility of similar capabilities which provides a similar level of care

AAI will not evacuate or repatriate a Participant:

- Without medical authorization
- With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local doctors and do not prevent the Participant from continuing his/her trip or returning home
- If the Participant is pregnant and beyond the end of the 28th week and with respect to the child born from the pregnancy, AAI will not evacuate or repatriate a child born while the Participant was traveling beyond the 28th week; and With mental or nervous disorders unless hospitalized

The timing and delivery of services may be impacted by the absence of valid worldwide health insurance coverage. All students enrolled in this program are required to have in force health insurance with worldwide coverage.

Exclusions:

- Travel by a Participant's spouse when it is for the benefit of the spouse's employer (spouse business travel)
- Trips exceeding the applicable eligibility period of the academic institution program in which the Participant is enrolled
- Students at their home or school campus addresses, as they are not considered to be travel status (except for medical repatriation and return of mortal remains services, which are available from their school campus address)

DESCRIPTION OF ASSIST AMERICA, INC. TRAVEL ASSISTANCE SERVICES

Definition of Program Eligibility:
(1)**U.S. STUDENT STUDYING AT U.S. CAMPUS :** A U.S. student studying at an U.S. campus location is eligible for all travel assistance services when traveling more than 100 miles (150km) from his or her legal residence and school campus addresses for less than one semester (approximately one hundred twenty (120) days); with the exception of Medical Repatriation and Return of Mortal Remains services, which are available while at his or her campus location; or
(2)**NON U.S. STUDENT STUDYING AT A U.S. CAMPUS:** A Non-U.S. student studying at an U.S. campus location is eligible for all Assist America services for the duration of his/her studies in the U.S. provided they have continued enrollment in the Assist America program. They are also eligible when traveling more than 100 miles (150km) from the U.S. campus for less than one semester (approximately one hundred twenty (120)) days or in a country which is not their country of residence for less than one semester (approximately one hundred twenty (120) days); or
(3)**STUDY ABROAD:** A student studying at an international academic location is eligible for all Assist America services at and away from the international campus location for up to one semester (approximately one hundred twenty (120) days).

When to contact Assist America:.
- If you require medical assistance or have a medical emergency.
- If you need assistance with a non-medical situation such as lost luggage, lost documents or other travel issues.

Helpful information to have available when you call Assist America:
- Policy number or school name
- Nature of your call and/or emergency
- Current location
- Contact phone number and email address
- Secondary point of contact
- Date of birth

For more information about Assist America/Scholastic Emergency Services, please visit www.assistamerica.com/students.html

Travel Assistance Website and Mobile App
Install the Assist America Mobile App which contains your membership ID card. Whenever you travel, if you need help, use the Tap for Help feature to be connected to our 24 hour Operations Center staffed by medically-certified personnel.

Features Include:
1. Coverage indicator that lets you know when you are eligible for assistance services
2. Pre-Trip Information such as visa requirements, immunizations, security advisories
3. Embassy/consulate locator
4. U.S. pharmacy locator

Complete the setup process by entering your Assist America reference number to unlock all of the features in the Assist America Mobile App.

Reference Number: 01-SES-CHP-111601

Medical Evacuation and Repatriation Benefits:
Up to a combined maximum limit of $1,000,000

DESCRIPTION OF VISION PLAN

Your Vision Plan provider is:
Madison Optical Center, **City Station, 658 West Washington, Madison, WI 53703**
Phone (608)-251-2020

Appointments at the Madison Optical Center must be scheduled in advance. Be sure to present your SHIP membership card to identify yourself as a SHIP member. All discounts will be off regular, non-sale retail price. If sale price is lower than plan discount price, sale price must be honored.

EYE EXAMS	➢ One Comprehensive Annual Eye Examination per person ➢ Contact Lens Standard Fitting Exam ➢ Specialty Contact Lens Fitting Exams	Covered Person Pays $0 Covered Person Pays $60 Covered Person Pays $70 per exam
EYEWARE DISCOUNTS		**Covered Person Discount**
	FRAMES ➢ Retail Price up to $140 ➢ Retail Price over $140	 20% Discount 25% Discount
	LENSES ➢ Single Vision ➢ Bifocal round seg ft. 25,28 ➢ Bifocal round, ft. 35 exec. Blended ➢ Progressive Bifocals ➢ Sola VIP, Adapter ➢ VIP Gold, Varilux, Percepta by Sola ➢ Trifocal 7/28 ➢ Trifocal 8/35 ➢ Cataract-Lenticular ➢ Cataract-Other	25% Discount
	SPECTACLE LENS ADD-ONS (Per Pair) ➢ Ultra Violet ➢ Anti-Reflective ➢ Fashion Tint ➢ Gradient Tint ➢ Photochromic ➢ Scratch Coat ➢ Roll & Polish Edges ➢ Standard Faceting ➢ Polycarbonate Single Vision ➢ Polycarbonate ft. 25, 28, 7/2 8 Trifocal ➢ Transition Plus Single Vision ➢ Transition Plus ft. 28 ➢ Transition Plus 7/28 Trifocal Progressive ➢ High Index Plastic Standard-1.56 ➢ High Index Plastic Deluxe-1.60 ➢ Sphere Power over 4 D or over 2.00 D Cylinder/pair/diapter ➢ Glass Lenses-single vision ➢ Glass Lenses-Bifocal lenses ➢ Glass Lenses Tint (add per pair for glass lenses only) ➢ All other lens add-ons not listed	25% Discount
EYEWARE SAVINGS	**SUNGLASSES** ➢ Any pair available at provider location	25% Discount
EYEWARE SAVINGS	**CONTACT LENSES** ➢ Conventional ➢ Disposable	 20% Discount 10% Discount
OTHER CHARGES	➢ **Broken Appointment**	$25