

# UMassAmherst

## UNDERGRADUATE STUDENT HEALTH BENEFITS PLAN (SHBP) PLAN DOCUMENT

**Effective: August 1, 2022**

For the most current information regarding the SHBP, refer to the SHBP web site at: [www.wellfleetstudent.com](http://www.wellfleetstudent.com)

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## INTRODUCTION

## SECTION I

This document has been prepared by The Plan Sponsor for Undergraduate Students that are enrolled in the University of Massachusetts Amherst Student Health Benefit Plan (SHBP). This health plan is a partially self-funded health benefits plan funded by The Plan Sponsor. The Claim Administrator has been designated by the Plan Sponsor to provide administrative services for the SHBP either directly or through contracting with an appropriate agency. Please take a few minutes to carefully read this document as it is designed to help the Covered Person understand their medical and prescription drug benefits. An overview of your coverage can be found in the Schedule of Benefits (see Table of Contents).

Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

This is a Preferred Provider Organization (PPO) health plan. That means each Covered Person has the ability to determine the costs that each will pay when they choose a provider to furnish their covered medical care.

Certain conditions and limitations affect the benefits you receive under the SHBP. We hope to help make you a wise consumer of health services and use only the services you need. Please be aware, even if your health care practitioner recommends them, not all kinds of treatments or services qualify as Covered Medical Expenses under the SHBP.

Please note that while most medical services charges are paid quickly, a few may require additional information from you before a payment is processed. If the Claims Administrator requests additional information, please respond quickly; failure to do so may result in non-payment from SHBP and you will be responsible for the charge.

Please contact the Claim Administrator: Wellfleet Group, LLC at (877) 657-5027 if you have any questions about your coverage. Please make note of the following elements of the SHBP:

### **(1) Preferred Provider Organization (PPO) Network Health Plan**

Benefits under this plan consist of three (3) levels:

- One for in-network benefits provided by University Health Services (UHS);
- One for in-network benefits provided by another PPO Provider; and
- One for out-network benefits.

The chosen Preferred Provider Network is a group of Physicians, Practitioners, and Hospitals who have contracted to accept a negotiated fee for their services. The costs you pay for Covered Medical Expenses will differ based on the benefit level and where the care is received. To receive the highest benefit level, obtain your health care services and supplies from UHS or other providers who participate in your PPO health care network. If you choose to obtain your health care services and supplies from a non-participating provider, you will usually receive the lowest level of benefit; that is you will have higher out-of-pocket charges.

The Cigna PPO network of Participating Providers is available at: [www.cigna.com](http://www.cigna.com) or contact Wellfleet Group toll free at (877) 657-5027, or [www.wellfleetstudent.com](http://www.wellfleetstudent.com) for assistance.

**Advantages of choosing UHS as your provider include:**

1. No out-of-pocket expenses, such as co-payments, co-insurance or deductibles, for medical services provided at UHS.
2. The convenience of an on-campus facility.
3. UHS provides comprehensive primary care, walk-in care, mental health services, referral and educational services, with a special focus on the health needs and concerns of Students.

**Advantages the SHBP provides for choosing an In Network Preferred Provider include:**

1. Usually your out-of-pocket expenses for health care services are less than at Out of Network providers.
2. The Covered Person is not responsible for charges greater than the fee the provider negotiated with the network for the Covered Medical Service itself. However, a Covered Person is responsible for any applicable co-payment, deductible, coinsurance or amount greater than the maximum benefit amount for that service.

**Advantages available to all SHBP members:**

1. Unlike an HMO plan, the SHBP does not require a Covered Person to select a PCP. While it is suggested that a Covered Person have one dedicated practitioner who coordinates all aspects of their care, selection of one is not required.
2. A Covered Person may change their provider and/or hospital at any time.
3. In most cases, claims will be filed directly so a Covered Person does not have to wait for claim reimbursement.

**(2) Pre-certification of care**

All inpatient hospital admissions, convalescent facility, skilled nursing facility and all inpatient maternity care after the initial 48/96 hours require pre-certification. If you do not secure pre-certification for non-emergency inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a \$200 per admission charge. For further details please review the Preadmission/Precertification section as listed in the table of contents.

**(3) Choices a Covered Person can make to maximize their cost savings for Covered Medical Expenses under the SHBP:**

- (a) When medically reasonable, have Surgery performed in an Ambulatory/Outpatient setting instead of as an Inpatient procedure. This will eliminate the Hospital Room and board charges intrinsic to an overnight Hospital stay.
- (b) When medically reasonable, consider discussing the potential effectiveness of generic drugs with your PCP. A generic drug is a prescription drug with the equivalency of a brand name drug with the same use, delivery system and metabolic disintegration.

**(4) Services provided in other countries**

Payment for covered medical expenses incurred by a Covered Person who is a citizen or permanent resident of the United States while outside the USA or its territories will be made on the same basis as covered medical expenses incurred while within the USA. Such benefits are provided to International Students and their covered Dependents only to the amount not covered by any system of socialized medicine, or insurance plan or program.

**(5) Impact of the Affordable Care Act (ACA)**

The Plan Sponsor has elected to voluntarily configure the benefits of the 2020-2021 plan year to comply with the regulations issued by the U.S. Department of Health and Human Service (HHS) as required by the Affordable Care Act (ACA) for fully insured student health insurance programs.

**GENERAL INFORMATION****SECTION II**

<b>Plan Name</b>	University of Massachusetts Amherst Undergraduate <b>Student Health Benefits Plan (SHBP)</b>
<b>Type of Plan</b>	Non-ERISA governed student health benefits plan providing medical and prescription drug benefits on a partially self-funded basis.
<b>Effective</b>	<b>Effective August 1, 2022</b>
<b>Plan Sponsor</b>	University of Massachusetts Amherst Amherst, MA 01003
<b>Group Number</b>	ST0941SH
<b>Plan Administrator</b>	University of Massachusetts Amherst
<b>Campus Plan Coordinator</b>	UHS Patient Services (413) 577-5192
<b>Claim Administrator</b>	Wellfleet Group, LLC PO Box 15369 Springfield, MA 01115-5369 (877) 657-5027 <a href="http://www.wellfleetstudent.com">www.wellfleetstudent.com</a>
<b>In-Network Providers</b>	Cigna PPO Network of Participating Providers
<b>Prescription Benefits Administrator</b>	WellfleetRX/ESI 800-482-1285 <a href="http://www.wellfleetrx.com">www.wellfleetrx.com</a>
	To see if your pharmacy is a participating pharmacy please visit: <a href="http://www.wellfleetrx.com/students/pharmacy-network/">www.wellfleetrx.com/students/pharmacy-network/</a>
<b>Case Management Services</b>	Cigna (877) 657-5027
<b>Medical Evacuation and Repatriation Provider</b>	Travel Guard
<b>Termination and/or Modification</b>	The Plan Sponsor may terminate the SHBP at the end of any Plan Year <i>or</i> change the provisions of the SHBP at any time by a written Plan Document amendment signed by a duly authorized officer of The Plan Sponsor. The consent of any Covered Person is not required to terminate or change the SHBP.

**NOTE:** The SHBP is a partially self-funded health plan. As such, it is not regulated by the State of Massachusetts's Department of Insurance. Similarly, it is important to note that the SHBP is not an employer-sponsored health plan. Consequently, the rules and regulations of the Consolidated Omnibus Budget Reconciliation Act of 1996 (COBRA), the Employee Retirement Income Security Act of 1974 (ERISA), and other federal laws that apply exclusively to employer sponsored health plans do not apply to the SHBP. The University of Massachusetts Amherst is voluntarily complying with the U.S. Department of Health and Human Services (HHS) (refer to Federal Register, 77 FR 16453) benefit requirements for fully insured student health insurance plans mandated in regulations for the 2013-2014 plan year. While the SHBP may voluntarily adopt certain practice as described under ERISA, the adoption of such practices are not to be deemed to subject the SHBP to ERISA.

Other federal laws and regulations that may apply to the SHBP include but are not limited to:

- Regulations of the United States Information Agency applicable to visa recipients
- Health Insurance Portability and Accountability Act of 1996 (HIPAA)
- Age Discrimination act of 1975
- Section 504 of the Rehabilitation Act of 1973
- Title IX of the Educational Amendments of 1972. Note: the SHBP provides pregnancy benefits on the same basis as any other temporary disability.

It is the policy of the University of Massachusetts Amherst to uphold the constitutional rights of all members of the UMass Amherst community and to abide by all applicable United States and University System of Massachusetts Amherst policies applicable to discrimination and harassment.

The University of Massachusetts Amherst prohibits discrimination on the basis of race, color, religion, creed, sex, age, marital status, national origin, mental or physical disability, veteran status, or sexual orientation, gender identity and expression, genetic information and any other class of individuals protected from discrimination under state or federal law in any aspect of access to, admission, or treatment of Students in its programs and activities. Furthermore, University Policy includes prohibitions of harassment of students and employees, i.e., racial harassment, sexual harassment, and retaliation for filing complaints of discrimination.

Full disclosure of the University of Massachusetts's Affirmative Action and Equity Policy may be found online at <http://www.umass.edu/eod/aapolicy.html>

**1. Eligible Students:**

See **SHBP ANNUAL SUPPLEMENTS SECTION XV** for specific Plan Year Eligibility.

**2. Late Enrollment:**

This section provides an option for Students, under certain circumstances, to be approved to enroll in the SHBP after the otherwise applicable enrollment deadline.

- a. If an Undergraduate student originally waived coverage under this SHBP plan, and later due to a qualifying life event, lost eligibility under that plan, the student will be considered a Late Enrollee under this plan. Such late enrollee must make a request for enrollment within thirty (30) days of loss of coverage and provide documentation showing the exact date the prior coverage will expire. An Undergraduate student enrolling late but within that thirty (30) day-time frame may also enroll Eligible Dependents. If an approved Student's request for coverage is made and applicable premium paid within the aforementioned thirty (30) day deadline, coverage under the SHBP will begin the day after the prior coverage ends.
- b. An eligible student who waived SHBP but for whom it is discovered does not have insurance coverage that meets Massachusetts requirements for comparability will be enrolled and billed for SHBP. Benefits for such students will begin the first of the month following enrollment in SHBP.
- c. An exception to that rule exists in the case of a Student who is under a court order (Qualified Medical Child Support Order) requiring the Student to provide coverage for his or her eligible dependent. In such a case, the dependent's effective date under the plan will be the effective date of the court order. Applicable premiums for the semester/plan year will apply.

**3. Enrollment/Waiver:**

See **SHBP ANNUAL SUPPLEMENTS SECTION XV** for specific Plan Year Enrollment and Waiver information.

Waiver submissions may be audited by the University of Massachusetts Amherst, Wellfleet Group, LLC and/or their contractors or representatives. An Undergraduate Student may be required to provide, upon request, any coverage documents and/or other records demonstrating that the Student meets the school's requirements for waiving the SHBP. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable plan year and that it meets the school's waiver requirements.

The Plan Administrator reserves the right to review, at any time, your eligibility to enroll in this Plan. If it is determined that you do not meet the school's eligibility requirements for enrollment, your participation in the Plan may be rescinded in accordance with its terms.

**4. Eligible Dependents:**

The subscriber must be enrolled in the SHBP and have paid the Student Health Fee in order to enroll their eligible Dependents.

To enroll their eligible Dependent(s), the subscriber must complete an Enrollment Form and submit it to UHS Patient Services. Charges for both the UHS Family Plan and the SHBP Family Plan will be added to your semester tuition and fees bill. Forms are available on the UHS website, [www.umass.edu/uhs](http://www.umass.edu/uhs), or at UHS. For more information, please call Patient Services at (413) 577-5192. Enrollment must be completed by the end of the Add/Drop period.



An eligible Dependent is one of the following persons:

- (1) A child of the Covered Student who has not attained 26 years of age.
- (2) A person who is the lawful spouse of the Covered Student.
- (3) A person for whom the covered student has completed and signed a “declaration of domestic partnership”.
- (4) An unmarried child of the person who has attained 26 years of age but is permanently and totally disabled\* (as defined by Internal Revenue Code Section 22 (e)(B)).

For purposes of determining eligibility, the term child includes:

- A biological child of the Student.
- A child for whom legal guardianship has been awarded to the Student. A legally adopted child.
- A child placed with the Student for adoption by a court with adequate jurisdiction.
- A stepchild by legal marriage, or
- An individual under age 26 for whom the Student is required to provide coverage due to a Qualified Medical Child Support Order.

A student must be enrolled in the SHBP and have paid the applicable fees in order to be able to enroll and insure their eligible dependents. A dependent’s coverage begins and ends with the Student’s coverage, except as provided for the dependent under the late enrollment provision. Under no circumstances shall a dependent’s coverage begin before the student’s coverage.

Dependents must be re-enrolled for coverage at the beginning of the fall and spring semesters in order to avoid a break in coverage.

\*At reasonable intervals during the two (2) years following a disabled child’s 26<sup>th</sup> birthday, the Plan Administrator may require subsequent proof of the dependent’s incapacity and dependency. After such two (2) year time frame the administrator may require proof of the dependent’s incapacity and dependency no more than once per plan year. The administrator has the right to have the dependent examined by a physician of the administrator’s choosing to determine the existence of claimed incapacity.

No person may be covered by the SHBP as both a Dependent and a Student. Additionally, one person cannot be covered by more than one Student. If both parents are students, only one Student may claim any given eligible dependent. However, if both parents are Students, one Student can be a Dependent of her / his spouse and still satisfy the requirement for coverage for full time students.

#### **5. Newborn Infant Coverage:**

A newborn child of any Covered Student is automatically covered at birth for thirty-one (31) days for Accident, Sickness, and congenital defects. The Covered Person may continue coverage for the newborn beyond the thirty-one (31) days upon application and payment of Family Plan premium within the thirty-one (31) day period from the date of birth.

#### **6. Adopted Child Provision:**

An adopted child will be covered for Accident, Sickness, and congenital defects for thirty-one (31) days from the date of filing a petition to adopt if the child has been residing in the home of the Covered Student as a foster child, or in all other cases, immediately from the date of placement of the child for

purposes of adoption in the home of a Covered Student. To continue coverage for an adopted child, the Covered Student must enroll the child within thirty-one (31) days of placement of such child along with signed court documents and pay any additional premium necessary starting with the date of placement.

The child's eligibility for coverage ceases upon the termination of the child's placement for adoption with the subscriber. Unless a legal obligation to maintain coverage, such as a Qualified Medical Child Support Order exists, the child's coverage shall cease after the last day of the month the placement is terminated.

**SCHEDULE OF BENEFITS**

**SECTION IV**

<b>University of Massachusetts – Amherst 2022-2023 Schedule of Medical Benefit</b>		
<b>BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Plan Year Maximum Benefit</b>	Unlimited Maximum Benefit	
<b>Plan Year Deductible</b>	\$200 per Individual \$600 per Family	
<b>Out-of-Pocket Maximum</b>	\$1,500 per Individual \$4,500 per Family	
<b>Wellness/Preventive and Immunizations Expenses.</b> (See page 13 for details)	100% of PA (deductible does not apply)	80% of R&C
<b>UHS Services</b> Please note: MOST services at UHS are provided at no additional cost. Students will be responsible for RX co-pays at UHS	Covered at 100% (deductible does not apply)	
<b>INPATIENT HOSPITALIZATION BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Hospital Room and Board Expense.</b> Services include semi-private room, nursing services and Intensive Care Unit (ICU).	90% of Preferred Allowance (PA)	80% of Reasonable and Customary Charges (R&C)
<b>Miscellaneous Hospital Expense.</b> Services include anesthesia (excluding professional administration fee), operating room, diagnostic x-ray, laboratory tests, Licensed Nurse, prescribed drugs & medicine, dressings, physical therapy, pre-admission testing, and other required non-Room and Board Hospital Expenses.	90% of PA	80% of R&C
<b>In-Hospital Physician Expenses.</b> Services of a Doctor during hospital confinement. This benefit does not apply when related to surgery.	90% of PA	80% of R&C
<b>Rehabilitation:</b> limited to a maximum of 45 days per plan year	90% of PA	80% of R&C
<b>Habilitation:</b> No limit for Habilitation services.	90% of PA	80% of R&C
<b><i>All inpatient hospital admissions, convalescent facility, skilled nursing facility and all inpatient maternity care after the initial 48/96 hours require pre-certification. If you do not secure pre-certification for non-emergency inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a \$200 per admission charge.</i></b>		
<b>SURGICAL BENEFITS (INPATIENT AND OUTPATIENT)</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Surgical Expense.</b> Expenses incurred for a surgical procedure, necessary pre-operative treatment in connection with such procedure and usual post-operative treatment.	90% of PA	80% of R&C
<b>Anesthesia Expense.</b> Charges of anesthesia during a surgical procedure.	90% of PA	80% of R&C
<b>Assistant Surgeon Expense.</b> Charges of an assistant surgeon during a surgical procedure.	90% of PA	80% of R&C
<b>Nurse Anesthetist and Nurse Practitioners.</b> Includes charges for services rendered by a certified registered nurse practitioner.	90% of PA	80% of R&C

<b>Ambulatory Surgical Expense.</b> Charges incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. Must be incurred on the date of surgery or within 48 hours after surgery.	90% of PA	80% of R&C
<b>OUTPATIENT BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Covered Medical Expenses</b> include but are not limited to, Physician's office visits, hospital or outpatient department or emergency room visits, durable medical equipment, clinical lab or radiological facility.		
<b>Hospital Outpatient Department or Walk-In Clinic Expense:</b> Incurred by a covered person for diagnostic x-ray and laboratory services, consultants or specialists, etc. Does not include expenses incurred by the use of an outpatient surgical facility.	90% of PA	80% of RC
<b>Emergency Room Expense.</b> Charges for treatment of an Emergency Medical Condition. (Co-pay waived if admitted)	100% of the PA after a \$100 co-pay per visit (deductible does not apply)	100% of the R&C After a \$100 co-pay per visit (deductible does not apply)
<b>Therapy Expense.</b> Includes speech therapy, inhalation therapy, occupational therapy, radiation therapy, chemotherapy, dialysis and respiratory therapy (Outpatient Physical Therapy visits limited to a 40-visit max per plan year.)	Office Visit: 100% of PA after \$20 co-pay per visit Physical Therapist: 90% of PA (deductible does not apply)	80% of R&C
<b>Chiropractic Care</b> (20 visits max per plan year-combined in and out-of-network).	90% of PA	80% of R&C
<b>Ambulance Expense.</b> Charges for a commercial, municipal or air ambulance for transportation to a Hospital or between Hospitals or other medical facilities in a Medical Emergency.	100% of Actual or Negotiated fee	
<b>Pre-Admission Testing Expense:</b> Charges incurred while outpatient before scheduled surgery.	90% of PA	80% of R&C
<b>Rehabilitation / Physical Therapy Expense.</b> Charges provided by a licensed physical therapist (40 visits max per plan year-combined in and out-of-network).	Office Visit: 100% of PA after \$20 co-pay per visit Physical Therapist: 90% of PA (deductible does not apply)	80% of R&C
<b>Habilitation</b> Limitation does not apply to Habilitation services.	Office Visit: 100% of PA after \$20 co-pay per visit Physical Therapist: 90% of PA (deductible does not apply)	80% of R&C
<b>Physician Office Visits/Primary Care Visits</b> (includes Pediatricians)	100% of PA after \$10 co-pay per visit (deductible does not apply)	80% of R&C

<b>Consultant or Specialist Visits</b>	100% of PA after \$20 co-pay per visit (deductible does not apply)	80% of R&C
<b>Telemedicine or Telehealth Services</b>	Payable the same as any other condition	
<b>Laboratory and X-ray Expense.</b> Includes diagnostic services, laboratory, and x-ray examinations.	90% of PA	80% of R&C
<b>High-Cost Procedures Expense.</b> Services include, but are not limited to C.A.T. Scans, MRI, and Laser Treatments.	90% of PA	80% of R&C
<b>Durable Medical Equipment Expense</b>	90% of PA	80% of R&C
<b>Dental Injury Expense</b>	90% of Actual or Negotiated fee	
<b>Impacted Wisdom Teeth Expense.</b> For removal of one or more impacted wisdom teeth.	90% of Actual or Negotiated fee	
<b>Pediatric Dental Services</b>  *Some Dental Services have age specific restrictions or may require Pre-authorization (see benefit description).	Pediatric Preventive Dental paid at 100%.  All other Pediatric Dental and other dental services subject to Deductible and Coinsurance Amount of 20% up to Out-of-Pocket Maximum.  Pediatric Dental Benefits are Limited to Covered Persons through the end of the calendar year in which they turn age 21	Pediatric Preventive Dental paid at 100%.  All other Pediatric Dental and other dental services subject to Deductible and Coinsurance Amount of 20% up to Out-of-Pocket Maximum.  Pediatric Dental Benefits are Limited to Covered Persons through the end of the calendar year in which they turn age 21
<b>Pediatric Vision Services</b>  *Some Pediatric Vision Procedures require pre-certification	Pediatric Preventive Vision paid at 100%.  All other Pediatric Vision is subject to Deductible and Coinsurance amount of 10% up to Out-of-Pocket maximum.  Pediatric Vision Benefits are Limited to Covered Persons through the End of the calendar year in which they turn age 19	Pediatric Preventive Vision paid at 100%  All other Pediatric Vision is subject to Deductible and Coinsurance amount of 20% up to Out-of-Pocket maximum.  Pediatric Vision Benefits are Limited to Covered Persons through the End of the calendar year in which they turn age 19
<b>Adult Vision Care (age 19 and older)</b> Routine Eye Exam once every 24 months	100% of R&C	100% of R&C
<b>Adult Vision Hardware</b> 1 pair of prescribed lenses and frames or contact lenses in lieu of lenses and frames per plan year	100% of actual cost up to a maximum of \$400	100% of actual cost up to a maximum of \$400
<b>Allergy Testing Expense</b>	90% of PA	80% of R&C
<b>Qualified Clinical Trial Expense</b>	Paid the same as any other condition.	

<b>MENTAL HEALTH BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Mental Health Disorder and Substance Abuse Inpatient Expenses</b>	90% of PA	80% of R&C
<b>Mental Health Disorder and Substance Abuse Outpatient Expenses</b>	100% of PA after \$20 co-pay per visit (deductible does not apply)	80% of R&C
<b>Autism Spectrum Disorder Expense</b>	Payable as any other Sickness	
<b>Diagnostic Testing for Attention Disorders and Learning Disabilities Expense:</b> Diagnostic testing for attention deficit disorder or attention deficit hyperactivity disorder.	90% of PA	80% of R&C
<b>MATERNITY BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Maternity Expense / Newborn Nursery Care:</b> Includes inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.	90% of PA	80% of R&C
<b>ADDITIONAL BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Wellness/Preventive and Immunizations Expenses.</b> Includes but is not limited to; Routine Physicals, Preventive Care Visits, Laboratory Services, Immunizations (including titers) & vaccines (including travel vaccines), GYN exams, Pap Tests, mammogram, prostate exam and PSA testing. <b>For more information, please visit:</b> <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a>	100% of PA (deductible does not apply)	80% of R&C
<b>Prescription Drug Benefit.</b> Prescriptions are not subject to the plan year deductible and should be purchased at University Health Services Pharmacy or through a participating pharmacy. <b>Participating Pharmacies can be found on-line at:</b> <a href="http://www.WellfleetRX.com/students/pharmacy-network/">www.WellfleetRX.com/students/pharmacy-network/</a> <i>(Note: Prescription Drugs considered to be wellness/preventive under the Affordable Care Act (ACA), including prescription contraceptives, are payable with no cost sharing. Co-payment will apply for a Brand drug when there is a Generic equivalent available.)</i>	Plan pays 100% of the Negotiated Rate after \$15 co-pay for a 30-day supply of a generic drug, \$0 co-pay for a 30-day supply of generic contraceptives, or \$30 co-pay for a 30-day supply of a brand name drug	
<b>Diabetic Testing Supplies &amp; Outpatient Diabetic Self-Management Education Program</b>	Payable as any other Sickness	
<b>Hypodermic Needles:</b> For medically necessary hypodermic needles and syringes.	Payable as any other Covered Medical Expense	

<b>ADDITIONAL BENEFITS</b>	<b>In-Network</b>	<b>Out-of-Network</b>
<b>Special Medical Formulas Expense</b>	90% of PA	80% of R&C
<b>Non-Prescription Enteral Formula Expense</b>	90% of PA	80% of R&C
<b>Elective Abortion Expense</b>	90% of PA	80% of R&C
<b>Elective Surgical Second Opinion Expense</b>	90% of PA	80% of R&C
<b>Acupuncture Expense</b> (limited to 20 visits per plan Year)	90% of PA	80% of R&C
<b>Acupuncture in Lieu of Anesthesia Expense</b>	90% of PA	80% of R&C
<b>Dermatological Expense:</b> Including charges for diagnosis and treatment of skin disorders, excluding laboratory fees. Related laboratory fees are covered under the outpatient expense benefit.	Payable as any other Covered Medical Expense.	
<b>Podiatric Expense:</b> Including charges provided on an outpatient basis following an injury.	Payable as any other Covered Medical Expense	
<b>Home Health Care Expense</b>	90% of PA	80% of R&C
<b>Hospice Care Expense</b>	90% of PA	80% of R&C
<b>Transfusion or Dialysis of Blood Expense:</b> Including the cost of whole blood, blood components and the administration thereof.	Payable as any other Covered Medical Expense.	
<b>Licensed Nurse Expense</b>	90% of PA	80% of R&C
<b>Skilled Nursing Facility Expense</b>	90% of PA	80% of R&C
<b>Rehabilitation Facility Expense</b>	90% of PA	80% of R&C
<b>Bone Marrow Transplants for Breast Cancer</b>	Payable as any other Sickness	
<b>Cardiac Rehabilitation Expense</b>	90% of PA	80% of R&C
<b>Speech, Hearing and Language Disorders Expense</b>	Payable as any other Sickness	
<b>Pediatric Preventive Care Expense</b>	100% of PA (deductible does not apply)	80% of R&C
<b>Early Intervention Services Expense</b>	100% of PA	100% of R&C
<b>Infertility Expense</b>	Payable on the same basis as any pregnancy-related procedure	
<b>Outpatient Contraceptive Drugs, Devices and Services Expense</b>	100% of PA	80% of R&C
<b>Hormone Replacement Therapy</b>	Payable as any other Covered Medical Expense.	
<b>Prosthetic Device Expense:</b> Including charges for artificial limbs, eyes or other non-dental prosthetic devices as a result of an accident or sickness.	90% of PA	80% of R&C
<b>Scalp Hair Protheses</b>	90% of PA	80% of R&C
<b>Hearing Screening for Newborns:</b> Performed before the newborn infant is discharged from the hospital or birthing center.	100% of PA (deductible does not apply)	80% of R&C
<b>Transplants Expense</b>	Payable as any other Sickness	
<b>Christian Science Healing Practices</b>	90% of PA	80% of R&C
<b>Urgent Care Expense</b>	90% of PA	80% of R&C
<b>Antigen Testing Expense</b>	Payable as any other Sickness	
<b>Morbid Obesity &amp; Bariatric Surgery Benefit</b>	Payable as any other Sickness	
<b>Medical Evacuation and Repatriation</b>	100% of Actual Charges	
<b>Family Travel Benefit</b>	100% up to \$2,500	
<b>Sport Accident Expense</b> – incurred as the result of the play or practice of Intercollegiate Sports Up to \$2,500 per Accident. (Deductible does not apply)	100% of PA	100% of R&C

**A. Inpatient Hospitalization Benefits****a. Hospital Room and Board**

- Charges made by a Hospital for room and board in a semiprivate room, Intensive Care Unit, cardiac care unit, or burn care unit, but excluding charges for a private room (unless Medically Necessary) which are in excess of the Hospital's semiprivate room rate.

**b. Miscellaneous Hospital Expense**

- Charges made by a Hospital for necessary medical supplies and services, including X-rays, laboratory, and anesthetics and the administration thereof; and
- Charges made by a Hospital for drugs and medicines obtained through written prescription by a Physician.

**c. In-Hospital Physician Expenses**

- Charges for the non-surgical services of the attending Physician, or a consulting Physician.

**d. Inpatient Rehabilitative/Habilitation Covered Services****- Rehabilitative Services**

Healthcare Services primarily for the purpose of therapeutic or rehabilitative treatment of the Participant (such as physical, occupational, speech, or oxygen therapy, etc.) are Covered Services.

- Limited to a maximum of forty-five (45) inpatient days per plan year.

**- Habilitative Services**

Healthcare Services primarily for the purpose of therapeutic or habilitative treatment of the Participant for Conditions which have limited the normal age-appropriate motor, sensory or communications development of the Participant are Covered Services if through the Habilitative Services, functional improvement and measurable progress is made toward achieving functional goals within a predictable period of time to reach the Participant's maximum potential development.

**NOTE:** All inpatient hospital admissions, convalescent facility, skilled nursing facility, and all inpatient maternity care after the initial 48/96 hours require pre-certification. If you do not secure pre-certification for non-emergency inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a \$200 per admission charge.

**B. Surgical Benefits (Inpatient and Outpatient)****a. Surgical**

- Expenses incurred for a surgical procedure, necessary pre-operative treatment in connection with such procedure and usual post-operative treatment.

**NOTE:** Necessary surgical procedures incidental to providing a wellness benefit required by the SHBP's voluntarily compliance with HHS guidelines will be covered at the same rate as any other Wellness expense. Surgical procedures not required under HHS regulations, such as vasectomies, will be paid as any other Covered Medical Expense.

**b. Anesthesia**

- Charges for Anesthesia during a surgical procedure.

**c. Assistant Surgeon**

- The SHBP will pay for a surgical assistant when the nature of the procedure is such that the services of an assistant, who is a Physician, are Medically Necessary.



**d. Nurse Anesthetist and Nurse Practitioners**

- Charges by a Physician including a Certified Registered Nurse Anesthetist or Nurse Practitioner for the administration of anesthesia incurred for a surgical operation.

**e. Ambulatory Surgical**

- Charges incurred for outpatient surgery performed at a Physician's office, Ambulatory Surgical Center, the outpatient department of a Hospital, Birthing Center or Freestanding Health Clinic.
- Charges must be incurred on the date of surgery or within 48 hours after surgery.

**f. Mastectomy**

When services relating to a mastectomy are medically necessary, coverage will include:

- Treatment of the physical complication of the mastectomy, including lymphedema.
- All stages of reconstruction of the breast on which the mastectomy was or is to be performed.
- Prosthesis; and
- Surgery and reconstruction of the other breasts to produce a symmetrical appearance.

**C. Outpatient Benefits**

**Covered Medical Expenses** include but are not limited to, Physician's Office Visits, Hospital or Outpatient Department or Emergency Room Visits, Durable Medical Equipment, Clinical Lab or Radiological Facility.

**a. Hospital Outpatient Department or Walk-in Clinic**

- Outpatient department charges.
- Benefits do not include expenses incurred for the use of an outpatient surgical facility.

**b. Emergency Room**

Charges incurred for Medically Necessary care at an emergency treatment center, walk in medical clinic or ambulatory clinic (including clinics located at a Hospital).

**c. Therapy**

- Charges for Inpatient respiratory, physical, occupational, inhalation, speech, and cardiac rehabilitation therapy.
- Charges for Outpatient inhalation/respiratory, occupational, speech, cardiac rehabilitation, radiation, chemotherapy, hemodialysis, and physical therapy:
  - Charges incurred for **inhalation/respiratory therapy** under the direct supervision of a Provider/Practitioner in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a freestanding duly licensed outpatient therapy facility.
  - Charges incurred for the treatment and services rendered by a registered **occupational therapist** to restore physical function and provided under the direct Supervision of a physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an Illness or Injury, or at a freestanding duly licensed outpatient therapy facility.
  - Charges incurred for the services of a legally qualified **speech therapist** under the direct supervision of a physician for restorative or rehabilitative speech therapy for speech loss or impairment, other than a functional nervous disorder, or due to surgery performed on account of an Illness or Injury. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.
  - Charges incurred for **cardiac rehabilitation** program in connection with documented cardiovascular disease. See Cardiac Rehabilitation Expense.
  - Charges for **radiation, chemotherapy, or hemodialysis** (renal therapy).

- Charges incurred for the treatment or services rendered by a **physical therapist** under direct supervision of a Physician in a home setting or a facility or institution whose primary purpose is to provide medical care for an illness or injury, or at a freestanding duly licensed outpatient therapy facility up to a maximum of limited to a maximum of forty (40) visits per plan year.
- d. Chiropractic Care**  
Charges made by a licensed chiropractor if such care is related to neuromusculoskeletal conditions and conditions arising from: the lack of normal nerve, muscle and /or joint function, up to a maximum of 20 visits per person, per Plan Year.
- e. Ambulance Services**  
Charges incurred for a professional ambulance for transportation:
1. For inpatient care to the nearest Hospital with appropriate facilities or, under similar restrictions, from one Hospital to another.
  2. For outpatient care to the nearest Hospital with appropriate facilities when such care is related to a Medical Emergency or an accident.
  3. From the nearest Hospital to the Participant's home, nursing home, or skilled nursing facility in the same locale.
- f. Pre-Admission Testing**  
Charges made for preadmission tests on an outpatient basis for a scheduled Hospital admission or surgery provided:
- The tests are done within seven (7) days of the planned admission, or surgery; and
  - The tests are accepted by the Hospital in place of the same post-admission tests.
- g. Outpatient Rehabilitative/Habilitation Covered Services**
- **Rehabilitative Services**  
Healthcare Services primarily for the purpose of therapeutic or rehabilitative treatment of the Participant (such as physical, occupational, speech, or oxygen therapy, etc.) are Covered Services.
    - Limited to a maximum of forty (40) visits plan year.
  - **Habilitative Services**  
Healthcare Services primarily for the purpose of therapeutic or habilitative treatment of the Participant for Conditions which have limited the normal age-appropriate motor, sensory or communications development of the Participant are Covered Services if through the Habilitative Services, functional improvement and measurable progress is made toward achieving functional goals within a predictable period of time to reach the Participant's maximum potential development.
- h. Physician Office Visits**  
Charges made by legally licensed Physician for medical care and/or treatment including office visits, hospital outpatient visits/exams, and clinic care.
- Coverage is also provided on a nondiscriminatory basis for covered services when delivered or arranged by a participating nurse practitioner with no annual service limitation that is less than other preferred care providers. If the services are in connection with surgery and the physician is the surgeon who performed the surgery, no benefits will be payable under this provision.

**i. Laboratory and x-ray**

Charges incurred for X-rays, microscopic tests, laboratory tests, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved and performed by Physicians throughout the United States.

**j. High-Cost Procedures Expense**

Charges incurred for diagnostic imaging and general imaging, including but not limited to, ultrasounds, MRI/MRA, CT/CAT, PET, and nuclear medicine.

**k. Durable Medical Equipment**

Coverage will be provided for no more than one (1) item of equipment for the same or similar purpose, the accessories needed to operate it, and/or the repair, maintenance, replacement, and adjustment of said equipment, that is:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to person who do not have said disease or injury,
- Not for use in altering air quality or temperature,
- Not merely for convenience or independence such as phone alerting systems, massage devices, over bed tables, communication aids, or other such item,
- Not for exercise or training.

**l. Dental Injury**

Coverage includes dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, and/or reposition sound natural teeth that are damaged, lost, or removed and other body tissues of the mouth fractured or cut due to a covered injury, provided:

- The tooth is free from decay, in good repair, and firmly attached to the jawbone at the time of the injury.
- The injury is from damage other than eating or chewing.
- The accident causing the covered injury must occur while the Covered Person is covered under this plan.
- Treatment is initiated/completed within one (1) calendar year of the accident.

Covered benefits include:

- The first denture or fixed bridgework to replace lost teeth,
- The first crown needed to repair each damaged tooth,
- An in-mouth appliance used in the first course of orthodontic treatment after the injury,
- Surgery needed to: treat a fracture, dislocation or wound; alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

**m. Impacted Wisdom Teeth Expense**

- Removal of one or more impacted wisdom teeth.

**n. Pediatric Dental Services**

The following Pediatric Dental Services are Covered Services for Covered Persons through the end of the calendar year in which they turn age twenty-one (21):

<b>PREVENTIVE AND DIAGNOSTIC SERVICES</b>
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 film
D0220 Intraoral- periapical first
D0230 Intraoral- periapical - each additional film
D0240 Intraoral- occlusal film
D0270 Bitewing- single film Adult -1 set every calendar year/Children -1 set every 6 months
D0272 Bitewings -two films -Adult -1 set every calendar year/Children -1 set every 6 months
D0274 Bitewings - four films Adult -1 set every calendar year/ Children -1 set every 6 months
D0277 Vertical bitewings-7 to 8 films-Adult-1 set every calendar year/Children -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
Preventative Services:
D1110 Prophylaxis-Adult- Limited to 1 every 6 months
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 22- 2 every 12 months
D1206 Topical fluoride varnish- Over age 22- 1 in 12 months; Less than age 22- 2 in 12 months
D1351 Sealant- per tooth- unrestored permanent molars - Less than age 19. 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 every 36 months
D1510 Space maintainer-fixed -unilateral-Limited to children under age 19
D1515 Space maintainer-fixed- bilateral-Limited to children under age 19
D1520 Space maintainer-removable-unilateral-Limited to children under age 19
D1525 Space maintainer-removable-bilateral-Limited to children under age 19
D1550 Re-cementation of space maintainer-Limited to children under age 19
Additional Procedures covered as Preventive and Diagnostic:
D9110 Palliative treatment of dental pain- minor procedure
<b>BASIC RESTORATIVE SERVICES</b>
<b>Minor Restorative Services:</b>
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
<b>Endodontic Services:</b>
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.
<b>Periodontal Services:</b>
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.
<b>Prosthetic Services:</b>
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 1 in a 36-month period, 6 months after the initial installation
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
<b>Oral Surgery:</b>
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
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 gingiva
<b>MAJOR SERVICES</b>
<b>Major Restorative Services:</b>
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
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
D2794 Crown-titanium- 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
<b>Endodontic Services:</b>
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)
D3450 Root amputation- per root
D3920 Hemisection (including any root removal)- not including root canal therapy
<b>Periodontal Services:</b>
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)
04355 Full mouth debridement to enable comprehensive evaluation and diagnosis- Limited to 1 per lifetime
<b>Prosthodontic Services:</b>
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
D5213 Maxillary partial denture- cast metal framework with resin denture base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months
D5214 Mandibular partial denture- cast metal framework with resin denture base (including any conventional clasps, rests and teeth)-Limited to 1 every 60 months
D5281 Removable unilateral partial denture one-piece cast metal (including clasps and teeth)-Limited to 1 every 60 month
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
D6053 Implant supported complete denture
D6054 Implant supported partial denture
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
D6060 Abutment supported porcelain fused to predominately base metal crown- 1 every 60 months
D6061 Abutment supported porcelain fused to noble metal crown 1 every 60 months
D6062 Abutment supported cast high noble metal crown - 1 every 60 months
D6063 Abutment supported cast predominately base metal crown – 1 every 60 months
D6064 Abutment supported Cast noble metal crown 1 every 60 months
D6065 Implant supported porcelain/ceramic crown- 1 every 60 months
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months
D6067 Implant supported metal crown- 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
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
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/on lay- 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
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 build up for retainer including any pins 1 every 60 months
D9940 Occlusal guard, by report- 1 in 12 months for patients 13 and older
<b>GENERAL SERVICES</b>
<b>Anesthesia Services:</b>
D9220 Deep sedation/general anesthesia- first 30 minutes

D9221 Deep sedation/general anesthesia- each additional 15 minutes
<b>Intravenous Sedation:</b>
D9241 Intravenous conscious sedation/analgesia- first 30 minutes
D9242 Intravenous conscious sedation/analgesia each additional 15 minutes
<b>Consultations:</b>
D9310 Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)
<b>Medications:</b>
D9610 Therapeutic drug injection, by report
<b>Post-Surgical Services:</b>
D9930 Treatment of complications (post-surgical) unusual circumstances, by report

**Limitations and Exclusions:**

- a. Pre-certification for services that require surgical intervention (see Precertification of care page 4 and page 36).
  1. A Physician other than a dentist or oral surgeon must certify that hospitalization is necessary to safeguard the life or health of the patient. Psychiatric reasons for admissions will not be considered hazardous medical conditions. If a Physician, dentist, or oral surgeon needs to perform a dental procedure for non-dental reasons, Benefits will be allowed only if written authorization is given by Blue Cross Blue Shield of Wyoming in advance of the date services are performed.
  2. Often there are several ways to treat a particular dental problem. For example, either a crown or a filling can perform equally well in certain situations. The same holds true in decisions about the use of precious metals versus amalgam. Before the alternate procedures provision is used, dental consultants will review the claim to verify that an alternate method of treatment would meet professional standards. If so, the payment is based on the less costly procedure if the result meets the accepted standards of dental practice. If the more costly procedure is performed, the Subscriber will be responsible for the excess amount over the benefits allowed for the less costly procedure.
- b. Restorations of the mouth, tooth, or jaw which are necessary due to an accidental injury are limited to those services, supplies, and appliances appropriate for dental needs. Non-covered items include: duplicate or "spare" dental appliances, personalized restorations, cosmetic replacement of serviceable restorations; and materials (such as precious metal) that are more expensive than necessary to restore damaged teeth.
- c. Benefits are not provided for mandibular staple implants, vestibuloplasty, or skin graft for atrophic mandible.
- d. Dentures and Bridgework: Benefits will not be provided for replacement of existing dentures or bridgework, except in the following cases:
  1. When existing partial dentures, full removable dentures or fixed bridgework cannot be made serviceable and were installed five years before replacement, and/or
  2. When replacement or installation of a denture or bridgework is due to necessary additional extractions or loss of teeth while individual is covered.
- e. Gold or other precious metals used in restorative or prosthodontic procedures will be payable at the semi-precious allowance.
- f. Replacement of stolen or lost prosthetic devices.
- g. Educational programs, such as training in plaque control or oral hygiene, or for dietary instructions.

- h. Appliances, restorations, and procedures to alter vertical dimension, including orthodontia and related services unless otherwise stated herein.
- i. To be eligible for any Medically Necessary Orthodontia Benefits covered under this Plan, the Dependent Child receiving the orthodontia Benefits must be enrolled in this Plan. Medically Necessary Orthodontic care is defined as the treatment of a malocclusion (including craniofacial abnormalities/anomalies) that compromise the patient's physical, emotional or dental health. This treatment should be based on a comprehensive assessment and diagnosis done by an orthodontist, in consultation with other health care providers when indicated.
- j. Myofunctional therapy and services and supplies related to temporomandibular joint dysfunctions and myofascial pain disorder.
  - 1. Extra sets of dentures or other prosthetic devices or appliances.
  - 2. Temporary or treatment dentures.
- k. As otherwise limited or excluded by Section VII: Medical Benefit Exclusions.

**o. Pediatric Vision Services**

The following Pediatric Vision Services are Covered Services for Covered Persons through the end of the calendar year in which they turn age Nineteen (19):

- a. Vision Examinations: Benefits will be provided for one (1) vision exam for each Participant per calendar year. Frames Benefits will be provided for one (1) frame for each Participant per calendar year. Covered Services include but are not limited to facial measurements, determination of interpupillary distances, and assistance in frame selection, fitting and adjustment.
- b. Lenses: Benefits will be provided for one (1) pair of lenses for each Participant per calendar year, providing there were no Benefits paid for contact lenses during the same calendar year.
- c. Contact Lenses: Contact lenses are covered as a substitute for conventional lenses and frames as indicated above. Benefits will be provided for contact lenses in lieu of lenses and frames for each Participant per calendar year, providing there were no Benefits paid for contact lenses during the same calendar year.

**Limitations and Exclusions:**

Services for the conditions of hypermetropia (far-sightedness), myopia (near-sightedness), astigmatism, anisometropia, aniseikonia, and presbyopia will be covered only as described under Covered Services above. In addition, benefits for refractions, eye glasses, contact lenses, visual analysis or testing of visual acuity, bio-microscopy, field charting, orthoptic training, the servicing of corrective lenses, and consultations related to such services will also be limited only to those Benefits, if any, described above.

- p. **Adult Vision Care** for Insured Persons age 19 and over. We will provide benefits for one (1) routine eye examination every 24 months and one (1) pair of prescribed lenses and frames or contact lenses in lieu of lenses and frames per plan year.
  - a. **Adult Vision Hardware** covered up to maximum of \$400 per Plan Year.

**q. Allergy Testing**

Covered charges include charges incurred for diagnostic testing of allergies and immunology services including but not limited to:

- Laboratory tests,
- Physician office visits (including visits to administer injections),
- Prescribed medication for testing,
- Other medically necessary supplies and services.

**r. Consultant or Specialist**

- Covered charges include expenses for the services of a consultant or specialist when referred by the UHS or the attending Physician for the purpose of confirming or determining a diagnosis.

**s. Qualified Clinical Trial**

Covered charges will include routine patient care costs and expenses for a clinical trial that meets the following conditions:

- The Covered Person meets the patient selection criteria enunciated in the study protocol for participation in said clinical trial is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition as defined under 42 USC § 300gg-8.
- The available clinical or pre-clinical data provides a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial and that benefits will be at least as effective as a non-trial alternative.
- The patient has provided documentation of informed consent for participation in the clinical trial, in a manner that is consistent with current legal and ethical standards.
- The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.
- A Peer review has been conducted on the clinical trial and is approved by one of the United States National Institutes of Health (NIH), a cooperative group or center of the NIH, a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants, the United States FDA pursuant to an investigational new drug exemption, the United States Department of Defense or Veterans Affairs, or, with respect to Phase II, III, and IV clinical trials only, a qualified institutional review board.
- The clinical trial does not unjustifiably duplicate existing studies.
- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training, and treat a sufficient volume of patients to maintain that expertise; and
- With respect to Phase I clinical trials, the facility shall be an academic medical center, or an affiliated facility, and the clinicians conducting the trial shall have staff privileges at said academic medical center.

**D. Mental Health or Substance Abuse Use Disorder:**

Mental Health Services and Substance Use Disorder Services for Conditions requiring psychotherapeutic treatment, rehabilitation from a substance use disorder or both are Covered Services for inpatient and outpatient services.

**E. Maternity Benefit:**

**a. Maternity**

- Prenatal care of the mother and/or fetus is treated as any other Covered Medical Expense.
- Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In such cases, covered services may include Home Visits, Parent Education, and assistance and training in breast or bottle-feeding and the performance of any necessary and appropriate

- clinical tests, provided, however, that the first (1<sup>st</sup>) home visit be conducted by a Registered Nurse, Physician, or certified nurse midwife, and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.
- Authorization is not needed for initial inpatient care, however, should care be needed longer than the 48/96 hours described above, written documentation of medical necessity may be required.
  - Covered medical expenses include services of a certified nurse midwife, provided that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner.
  - Complications of pregnancy, including spontaneous and non-elective abortions are considered a sickness and are covered under this benefit. See "Elective Abortion Expense" for details on how a Voluntary or Elective Abortion would be covered.
  - Charges made by a Birthing Center or Freestanding Health Clinic (Payment will be limited to the amount that would have been paid if that person were in a Hospital.)

**b. Newborn Nursery Care:**

Covered Charges will include benefits for routine care of a covered person's newborn child as follows:

- Hospital charged for routine nursery care during the mother's confinement, but for not more than four (4) days for a normal delivery;
- Physician's charges for circumcision; and
- Physician's charges for visits to the newborn child in the hospital and consultations, but not for more than one (1) visit per day.

**F. Additional Benefits:**

**a. Wellness/Preventive and Immunizations**

As part of the University's voluntary adoption of the U.S Department of Health and Human Services (HHS) benefit requirements for fully insured student health insurance plans, the SHBP will be providing wellness benefits in accordance with government guidelines as listed at: [www.healthcare.gov/coverage/preventive-care-benefits](http://www.healthcare.gov/coverage/preventive-care-benefits) The following is a sample of the benefits considered preventive under the Affordable Care Act (ACA) as required by HHS Regulations in accordance with USPSTF, HRSA and ACIP.

**1. Covered Preventive Services for Adults (a Covered Person age 21 and older)**

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults over age 50.
- Depression screening for adults.
- Type 2 diabetes screening for adults with high blood pressure.
- Diet counseling for adults at higher risk for chronic disease.
- Hepatitis B screening for people at high risk, including people from countries with 2% or more Hepatitis B prevalence, and U.S.-born people not vaccinated as infants and with at least one parent born in a region with 8% or more Hepatitis B prevalence.

- Hepatitis C screening for adults at increased risk, and one time for everyone born 1945 – 1965
- HIV screening for all adults at higher risk.
- Immunization vaccines for adults (doses, recommended ages, and recommended populations vary):
  - Diphtheria
  - hepatitis A
  - hepatitis B
  - herpes zoster
  - human papillomavirus (HPV)
  - influenza (flu shot)
  - measles
  - meningococcal
  - mumps
  - pertussis
  - pneumococcal
  - rubella
  - tetanus
  - varicella (Chickenpox)
- Lung cancer screening for adults 55 - 80 at high risk for lung cancer because they're heavy smokers or have quit in the past 15 years
- Obesity screening and counseling
- Sexually transmitted infection (STI) prevention counseling for adults at higher risk
- Syphilis screening for adults at higher risk
- Tobacco Use screening for all adults and cessation interventions for tobacco users

## **2. Covered Preventive Services for Women, including Pregnant Women**

- Anemia screening on a routine basis for pregnant women.
- Bacteriuria urinary tract or other infection screening for pregnant women.
- BRCA counseling about genetic testing for women at higher risk.
- Breast cancer mammography screenings every 1 to 2 years for women over 40 years.
- Breast cancer chemoprevention counseling for women at higher risk.
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women.
- Cervical cancer screening for sexually active women.
- Chlamydia infection screening for younger women and other women at higher risk.
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
- Domestic and interpersonal violence screening and counseling for all women.
- Folic acid supplements for women who may become pregnant.
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes.
- Gonorrhea screening for all women at higher risk.
- Hepatitis B screening for pregnant women at their first prenatal visit.

- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women.
- Human papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are age 30 or older.
- Osteoporosis screening for women over age 60 depending on risk factors.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco screening and interventions for all women, and expanded counseling for pregnant tobacco users.
- Sexually transmitted infections (STI) counseling for sexually active women.
- Syphilis screening for all pregnant women or other women at increased risk.
- Well-woman visits to obtain recommended preventive services for women under age 65.

### **3. Covered Preventive Services for Children (a Covered Person up to age 21)**

- Alcohol and Drug Claims Administrator assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children of all ages (up to age 21).
- Blood Pressure screening for children (up to age 21).
- Cervical Dysplasia screening for sexually active females.
- Congenital Hypothyroidism screening for newborns.
- Depression screening for adolescents.
- Developmental screening for children under age 3, and surveillance throughout childhood.
- Dyslipidemia screening for children at higher risk of lipid disorders (up to age 21).
- Fluoride chemoprevention supplements for children without fluoride in their water source.
- Gonorrhea preventive medication for the eyes of all newborns.
- Hearing screening for all newborns.
- Height, weight and body mass index measurements for children. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years, and 18 to 21 years)
- Hematocrit or hemoglobin screening for children.
- Hemoglobinopathies or sickle cell screening for newborns.
- HIV screening for adolescents at higher risk.
- Immunization vaccines for children from birth to age 21 (doses, recommended ages, and recommended populations vary) including:
  - diphtheria, tetanus, pertussis
  - haemophilus influenzae type b
  - hepatitis a
  - hepatitis b
  - human papillomavirus
  - inactivated poliovirus
  - influenza (flu shot)
  - measles, mumps, rubella
  - meningococcal
  - pneumococcal

- rotavirus
- varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia.
- Lead screening for children at risk of exposure.
- Medical history for all children throughout development. (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years, and 18 to 21 years)
- Obesity screening and counseling.
- Oral health risk assessment for young children (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years).
- Phenylketonuria (PKU) screening for this genetic disorder in newborns.
- Sexually transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk.
- Tuberculin testing for children at higher risk of tuberculosis (ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, and 15 to 17 years, and 18 to 21 years).
- Vision screening for all children.

**b. Prescription Drug Benefit**

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered condition. Prescription drugs include:

- “Off-label” drugs for the treatment of HIV/Aids or cancer, will not be excluded on the grounds that the drug has not been approved by the U.S. FDA for that indication if such drug is recognized for the treatment of such indication in one (1) of the standard reference compendia, in medical literature.
- Services associated with the administration of a Prescription drug are covered as any other medical necessary service when recommended by the treating Physician as part of the Prescription.
- This benefit includes blood glucose monitoring strips, urine glucose strips, ketone strips, lancets, insulin syringes, insulin pumps and insulin pump supplies, insulin pens, insulin and oral medications. A co-payment will be required for a thirty (30) day supply.
- Note: Prescription Drugs considered to be wellness/preventive under the Affordable Care Act (ACA), including prescription contraceptives, are payable with no cost sharing. Co-payment will apply for a Brand drug when there is a Generic equivalent available. If, however, a generic version is not available, or would not be medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then a plan or issuer must provide coverage for the brand name drug in accordance with the requirements of the interim final regulations (that is, without cost-sharing, subject to reasonable medical management)."

**c. Diabetic Testing Supplies & Outpatient Diabetic Self-Management Education Program**

- Charges incurred for diabetic self-management training, education services, supplies and equipment for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy.
- Benefits include:
  - expense for blood glucose monitors.
  - blood glucose monitoring strips for home use.
  - voice-synthesizers for blood glucose monitors for use by the legally blind.
  - visual magnifying aids for use by the legally blind.



- urine glucose strips,
- ketone strips,
- lancets,
- insulin,
- insulin syringes,
- prescribed oral diabetes medications that influence blood sugar levels,
- laboratory tests, including glycosylated hemoglobin, or HbA1c tests,
- urinary/protein/microalbumin and lipid profiles,
- insulin pumps and insulin pump supplies,
- insulin pens,
- so-called, therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist.
- supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

**Note:** A co-payment for a 30-day supply would apply to items payable under the prescription drug benefit.

**d. Hypodermic Needles**

Covered charges include coverage for medically necessary Hypodermic needles and syringes.

**e. Special Medical Formulas**

Covered charges include special medical formulas for newly born infants, adoptive children, and if medically necessary a pregnant woman with phenylketonuria. The formulas must be approved by the Commissioner of the Department of Public Health for the medically necessary treatment of: Homocystinuria, Methylmalonic academia, Maple Syrup Urine Disease, Phenylketonuria, Propionic academia, Tyrosinemia, and for the screening of lead poisoning.

**f. Non-Prescription Enteral Formula**

Covered Charges include Non-Prescription Enteral formulas for which a Physician has issued a written order. Such formulas must be medically necessary for the treatment of malabsorption caused by:

- Ulcerative Colitis,
- Chronic intestinal pseudo-obstruction,
- Crohn's disease,
- Gastroesophageal motility,
- Gastroesophageal reflux, and
- Inherited diseases of amino acids and organic acids (including food products modified to be low protein).

**g. Elective Abortion**

- Covered Medical Expenses for an elective abortion

**h. Elective Surgical Second Opinion**

Charges incurred for a second surgical opinion, are as follows:

- (1) fees of a specialist Physician for a second surgical consultation when non-Emergency or elective surgery is recommended by the Covered Person's attending Physician (The Specialist

Physician rendering the second opinion regarding the Medical Necessity of such surgery must be board certified in the medical field relating to the surgical procedure being proposed; and  
(2) Covered Charges will include expenses for required x-rays and diagnostic tests done in connection with that consultation.

**i. Acupuncture**

Covered Charges as described in the schedule of benefits will include services administered by a legally qualified Physician participating within the scope of their license.

**j. Acupuncture in Lieu of Anesthesia**

Covered Charges as described in the schedule of benefits will include services administered by a legally qualified Physician participating within the scope of their license for:

- Adult postoperative and chemotherapy nausea and vomiting;
- Nausea due to Pregnancy;
- Postoperative dental pain;
- Chronic low back pain secondary to osteoarthritis; and
- Fibromyalgia/myofascial pain.

**k. Dermatological**

Covered Charges include diagnosis and treatment of skin disorders. Any associated laboratory fees would be provided under the Laboratory expense.

**l. Podiatric**

Covered Charges include medically necessary Outpatient Podiatric services following an injury.

**m. Home Health Care**

Covered Charges include medically necessary expenses incurred by a Covered Person for Home Health Services in accordance with a Home Health Care Plan (HHCP) written by the treating Physician.

- Such expenses will only be covered if:
  - Services are furnished by, arranged by, or under the direction of a licensed Home Health Agency.
  - Services are rendered under a HHCP. The plan must be established by the written order of the attending physician. Such plan must be reviewed by the attending physician every sixty (60) days. Such physician must certify that the proper treatment of the condition would require Inpatient Confinement in a Hospital or Skilled Nursing Facility if the services and supplies were not provided under the Home Health Care Plan. The attending physician must examine the covered person at least once a month.
  - Unless specifically provided in the plan, services are to be delivered in the Covered Person's place of residence on a part-time, intermittent visiting basis.
  - Services must be provided by a certified professional operating within the scope of their license.
  - Each visit that last for a period of four (4) hours or less is treated as one (1) visit.
- No benefits will be provided for services and supplies:
  - Not included in the Home Health Plan;
  - Services of any social worker, transportation services, Custodial Care and housekeeping;
  - For services of a person who ordinarily resides in the home of the Covered Person, or is a close relative of the Covered Person.

**n. Hospice Care**

Hospice care benefits are provided to a terminally ill Covered Person with a life expectancy of less than six (6) months; Benefits are limited to:

- (1) Inpatient Care in a Hospital or Hospice facility.
- (2) Ancillary charges furnished by the facility while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an Injury or Illness.
- (3) Medical supplies, drugs, and medicines prescribed by the attending Physician, but only to the extent that such items are necessary for pain control and management of the terminal condition.
- (4) Services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.), on a part time basis (up to 8 hours in one (1) day).
- (5) Home Health aide services.
- (6) Medical social services by licensed or trained social workers, psychologists, or counselors under the direction of a physician, including the assessment of the person's social, emotional, medical, and dietary needs and assessment of the home and family situation.
- (7) Identification of available community resources and assistance in obtaining those resources as noted in the covered person's assessed needs.
- (8) Nutrition services provided by a licensed dietitian.
- (9) Respite care for up to 5 days in any 30-day period; and
- (10) Bereavement counseling.

Bereavement counseling is a support service provided to Covered Person's immediate family both prior to and after the death of the Covered Person. Such visits are to assist in adjusting to the death. Benefits will be payable provided:

- (a) On the date, immediately before his or her death, the terminally ill person was in a Hospice Plan of Care program and was a Covered Person under the SHBP; and
- (b) Charges for such services are incurred by the Covered Person(s) within twelve (12) months of the terminally ill person's death.

The term immediate family means: parents, spouse (or same-sex domestic partner) and children of the terminally ill Covered Person.

Bereavement Counseling does not include funeral arrangements; financial or legal counseling; or homemaker or caretaker services (not otherwise provided in the Home Health Care Plan).

**o. Transfusion or Dialysis of Blood**

Covered charges for administration of infusions and transfusions (This includes the cost of unreplaced blood and blood plasma or autologous blood and blood plasma. Expenses for storage of autologous blood or blood plasma will not be covered.)

**p. Licensed Nurse**

Covered Charges include charges incurred by a covered person who is confined in an Inpatient basis and requires the medically necessary services of a register nurse or licenses practical nurse, provided that the nurse is not an immediate family member or reside in the Covered Person's home.

**q. Skilled Nursing Facility**

- **Skilled Nursing/Extended Care Facilities:** Inpatient confinement in a Skilled Nursing/extended care facility and/or in a rehabilitation facility/Hospital is provided if:
  - Is in lieu of confinement in a hospital on a full-time inpatient basis.
  - Charges are incurred within twenty-four (24) hours following a Hospital confinement for the same or related cause as the confinement.
  - The attending Physician certifies that twenty-four (24) hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the Hospital confinement.

**r. Rehabilitation Facility**

Covered Charges for expenses incurred by a covered person for confinement as a full time Inpatient in a Rehabilitation Facility. Confinement must follow within 24 hours of and be for the same or related cause(s) as, a period of Hospital or Skilled Nursing facility confinement.

**s. Bone Marrow Transplants for Breast Cancer**

Covered Charges for expenses incurred by a covered person who has been diagnosed with breast cancer that has progressed to the metastatic disease as follows:

- If recommended by the treating oncologist, referral to and participation in clinical trial on the grounds that the proposed procedure shows promise as a useful treatment for the Covered Person's Cancer and is likely to be at least as effective as conventional treatment.
- A bone marrow transplant, provided the Covered Person meets the criteria established for enrollment in a clinical trial even if not formally enrolled in the clinical trial; and
- Coverage for the bone marrow transplant itself.

The clinical trial will be conducted:

1. At a licensed health facility, which participates in a National Cancer Institute (NCI) sponsored or approved research in any cancer specialty area, or
2. At a licensed health facility, which has a formal agreement with an academic medical center to provide bone marrow transplantation as part of an NIC sponsored approved research protocol.

Definitions:

"Bone Marrow Transplant" means use of high dose chemotherapy and radiation in conjunction with transplant of autologous bone marrow or peripheral blood stem cells which originate in the bone marrow.

"Metastatic Disease" means Stage III and Stage IV breast Cancer, as well as stage II breast cancer which has spread to ten (10) or more lymph nodes, as defined by the American College of Surgeons.

**t. Cardiac Rehabilitation**

Such treatment shall be initiated within 26 weeks after the diagnosis of such disease and be recommended by the attending Provider/Practitioner. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, highly supervised with a tailored exercise program with continuous monitoring during exercise. Phase II consists of outpatient supervised treatment for Covered Persons who have left the Hospital but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the Covered Person's individual needs. Benefits are not payable for Phase III, which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.

**u. Speech, Hearing and Language Disorders**

Covered Charges include medically necessary diagnosis and treatment of speech; hearing; and language disorders if the charges are made for:

- Diagnostic Services rendered to find out if: and to what extent; a covered person's ability to speak or hear is lost or impaired.
- Rehabilitative services rendered that are expected to restore or improve a covered person's ability to speak or hear.

This benefit does not include charges:

- For any ear or hearing exam to diagnose or treat a disease or injury
- For drugs or medications
- For any hearing care service or supply which is a covered expense in whole or in part under any other part of this plan or under any other group plan.
- For any hearing care service or supply which does not meet professionally accepted standards
- For hearing aids, hearing evaluation tests, hearing aid batteries, and the fitting of prescription hearing aids
- For any exam which:
  - Is required by an employer as a condition of employment; or
  - Is required to provide under a labor agreement; or
  - Is required by any law of government.
- For Special Education (including lessons in sign language) to instruct a covered person, whose ability to speak or hear is lost or impaired, to function without that ability.
- For diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - That any school system, by law, must provide; or
  - As to speech therapy, to the extent such coverage is already provided for under Early Intervention and Home Health Care Services.
  - For any services unless they are provided in accordance with a specific treatment plan, which details the treatment to be rendered and the frequency and duration of the treatment; and
  - Provides for ongoing services and is renewed only if such treatment is still medically necessary.

**v. Pediatric Preventive Care**

Includes covered charges for physical examination, history measurements, sensory screening, neuropsychiatric evaluation, and developmental screening, and assessment of dependent children of the covered person from birth through age twenty-one (21). Services shall include hereditary and metabolic screening at birth, appropriate immunization and tests recommended by the physician.

**w. Early Intervention Services**

Benefits will be provided for Early Intervention Services delivered by certified early intervention specialists for children from birth until their third (3<sup>rd</sup>) birthday.

**x. Infertility**

Benefits will be payable for infertility procedures. Infertility is the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year if the female is age thirty-five (35) or younger or during a period of six (6) months if the female is over the age of thirty-five (35). For purposes of meeting the criteria of infertility, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she

attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one (1) year or six (6) month period, as applicable. Benefit includes expense incurred for the following non-experimental infertility procedures: artificial insemination (AI); in vitro fertilization and embryo placement (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer; intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility; and sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any. Coverage is not limited to sperm provided by the Covered Person's spouse. Coverage does not include: any experimental infertility procedure; surrogacy; reversal of voluntary sterilization, and cryopreservation of eggs.

**y. Outpatient Contraceptive Drugs, Devices and Services**

Covered Charges include:

- Charges incurred for Contraceptive drugs and devices that have been approved by the FDA and legally require a Physician's prescription.
- Related Outpatient services such as: consultations, exams, procedures, and other contraceptive related services and supplies.

Covered Charges do not include:

- Charges incurred while confined on an Inpatient basis; and
- Charges incurred for duplicate, lost, stolen, or damaged contraceptive devices.

**NOTE:** Necessary surgical procedures incidental to providing a wellness benefit required by the SHBP's voluntarily compliance with HHS guidelines will be covered at the same rate as any other Wellness expense. Surgical procedures not required under HHS regulations, such as vasectomies, will be paid as any other Covered Medical Expense.

**z. Hormone Replacement Therapy**

Benefits will be payable for Hormone Replacement Therapy outpatient services and supplies for peri and post-menopausal women including outpatient prescription drugs or devices.

**aa. Prosthetic Device**

Covered Charges include artificial limbs, or eyes, and other non-dental prosthetic devices that are medically necessary as the result of an injury or illness.

Except as specifically provided in the Schedule of Benefits, Covered Charges do not include: Eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet (except as required to prevent complication from diabetes).

**bb. Scalp Hair Protheses**

Charges for medically necessary wigs and artificial hairpieces, worn for hair loss resulting from any form of cancer or leukemia treatment.

**cc. Hearing Screening for Newborns**

Covered charges for hearing Screening service rendered to a dependent child performed before the newborn infant is discharged from the hospital or birthing center.

**dd. Transplants**

Covered charges include services or supplies in connection with non-experimental/non-investigational organ and bone marrow transplants that are medically necessary. Covered transplants include but are not limited to: Cornea, Human heart, lung, liver, kidney, pancreas, and bone marrow (including metastatic breast cancer).

**ee. Christian Science Healing Practices**

Benefits include charges incurred by a covered person for the healing practices of Christian Science.

**ff. Urgent Care**

Covered charges include treatment by an urgent care provider to evaluate and treat a non-emergency condition.

A covered person should not seek medical care or treatment from an urgent care provider if their illness, injury, or condition is an emergency condition. The covered Person should call 911 or go directly to the emergency room of a hospital for medical assistance.

A covered person should not be discouraged from exercising the option of calling the local pre-hospital emergency medical service system by dialing 911 (or its local equivalent) when he or she is confronted with an emergency medical condition.

**gg. Antigen Testing**

Coverage will be provided for Human Leukocyte Antigen or Histocompatibility Locus Antigen testing necessary to establish bone marrow transplant donor suitability. Coverage shall include the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health.

**hh. Morbid Obesity & Bariatric Surgery Benefit**

Coverage will be provided for gastric bypass surgery for morbid obesity (also known as bariatric surgery), once per lifetime when the Participant is twice or more the ideal weight, or 100 pounds or more above the ideal weight, whichever is greater. This is determined by accepted standard weight tables for frame, age, height, and sex; the condition of morbid obesity must be of at least five (5) year duration; and, non-surgical methods of weight reduction must have been unsuccessfully attempted for at least five years under a Physicians' supervision.

**ii. Medical Evacuation and Repatriation**

**EMERGENCY MEDICAL EVACUATION BENEFIT**

If the Covered Person sustains an Accidental Injury or Emergency Sickness while Insured under the Policy, We will pay for the actual charges Incurred for an emergency medical evacuation of the Covered Person to or back to the Covered Person's home country or country of regular domicile. Before We make any payment, We require written certification by the Attending Physician that the evacuation is Medically Necessary. Any expense for medical evacuation requires Our prior approval and coordination. This Benefit does not include the transportation expense of anyone accompanying the Covered Person or visitation expenses.

The Physician ordering the Emergency Evacuation must certify that the severity of the Insured's Injury or Emergency Sickness warrants his Emergency Evacuation. All transportation arrangements made must be by the most direct and economical conveyance and route possible.

**REPATRIATION OF REMAINS BENEFIT**

If the Covered Person dies while Insured under the Policy, We will pay for the actual charges incurred for embalming, and/or cremation and returning the body to his place of permanent residence in his home country or country of regular domicile. Expenses for repatriation of remains require the Policyholder's and Our prior approval. If You are a United States citizen, Your Home Country is the United States. This Benefit does not include the transportation expense of anyone accompanying the body, visitation or lodging expenses or funeral expenses.

## FAMILY TRAVEL BENEFIT

If the Insured is Hospital Confined due to an Accidental Injury or Emergency Sickness for more than seven (7) days while traveling outside of his/her Home Country, We will pay for expenses reasonably Incurred up to a maximum Benefit of \$2,500 for the cost to bring one person designated by the Insured to and from the Hospital or other medical facility where the Insured is Confined if the Insured is alone. Expenses will be limited to the cost for one economy round-trip airfare ticket, and the hotel accommodations in, the place of the Hospital Confinement.

Payment for meals, ground transportation and other incidentals are the responsibility of the Family Member or friend. With respect to anyone (1) trip, this Benefit is payable only once for that trip, regardless of the number of Covered Persons on that trip. No more than one (1) visit may be made during any twelve (12) month period. No benefits are payable unless the trip is approved in advance by the Administrator.

All transportation arrangements made must be by the most direct and economical conveyance and route possible.

### Emergency Medical and Travel Assistance Program

Travel Guard services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence. Travel Guard is your key to travel security.

For general inquiries regarding the travel access assistance services coverage, please call Wellfleet Group, LLC at 1-877-657-5027.

If you have a medical, security, or travel problem, simply call Travel Guard for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 or if you are in a foreign country, call collect at: 715.295.9311.**

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. Travel Guard will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

## PREADMISSION/PRE-CERTIFICATION / CASE MANAGEMENT

## SECTION VI

Pre-certification simply means contacting the Claim Administrator prior to treatment to obtain approval for a medical procedure or service. This may be done for you by your doctor, a hospital administrator, or one of your relatives (if they possess a written Protected Health Information (PHI) letter granting access to your health information). All requests for certification must be obtained by contacting the Claim Administrator.

If you do not secure pre-certification for a non-emergency inpatient admission or provide notification for an emergency admission within one (1) business day you will be subject to a charge of \$200 per admission. This per admission charge cannot be used to satisfy co-payments, deductibles, or out-of-pocket maximums described herein.



Pre-certification is required for the following inpatient or outpatient services or supplies:

- All inpatient admissions to a hospital, convalescent facility, skilled nursing facility, Documentation must include projected length of stay. In the event the number of days of hospitalization exceeds the number of pre-certified days, the additional days will not be an eligible expense under the provisions of this SHBP, unless certified as Medically Necessary care by the Plan Administrator.
- Inpatient maternity care lasting longer than the initial 48 hours for a vaginal delivery or after the initial 96 hours for a cesarean delivery. Documentation must be provided as to expected extension of stay.
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

Pre-certification does not guarantee the payment of benefit for your inpatient admission. Each claim is subject to review in accordance with the exclusions and limitations contained in the Plan, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Health Plan.

Pre-certification of Non-Emergency Inpatient Admissions and Home Health Services must take place at least three (3) business days prior the planned admission or date the services are scheduled to begin.

In the case of an Emergency Admission, the Covered Person, their physician, representative, or care center must contact the Claim Administrator within one (1) business day following the Emergency Admission. If the Covered Person is confined to the Hospital's observation area for more than 24 hours, it is necessary that the Covered Person contact the Claim Administrator within 48 hours after an admission or on the first business day following admission. If authorization is not obtained, the reduction in benefits described above applies.

## **Case Management Provision for Alternate Treatment**

In cases where a Covered Person's condition is, or is expected to be, of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified agency. This service involves the cost-effective voluntary management of a potentially high-cost claim for a high-risk or long-term medical condition. The intention of the service is to plan necessary, quality care in the most cost-effective manner with the approval of the Covered Person, the family of the Covered Person, and the Primary Care Physician (PCP).

In the event a Covered Person is identified as a candidate for case management a treatment plan is developed and implemented. Such plan is created and approved with input from the Primary Care Physician, the Covered Person, and the Case Management Agency. If either the Primary Care Physician and/or the Covered Person do not wish to follow the developed plan, treatments will continue, and benefits will be paid according to the SHBP.

Most of the time, large case management treatment will contain options regularly covered under the SHBP. However, in certain cases, the most medically appropriate and cost-effective care may be in a setting or manner not usually covered by the SHBP. In such cases, all Medically Necessary aspects of the approved treatment will be covered under the terms of the SHBP. Such exceptions will be determined on a case by case basis. In no way will an exception be considered as setting a precedent or creating a future liability for any Covered Person. All regular SHBP provisions would still apply.

No benefits shall be paid under the SHBP for the following expenses:

1. Expenses incurred as a result of dental treatment to the teeth, gums, jaw or structures directly supporting the teeth, including surgical extraction of teeth, Temporomandibular Joint Dysfunction (TMJ) or skeletal irregularities of one or both jaws including orthognathia and mandibular retrognathia except as specifically provided in the Schedule of Benefits.
2. Expenses incurred for services normally provided without charge by the school, or University Health Services and its health care providers.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, or duplicate spare eyeglasses, lenses or frames, non-prescription lenses or contact lenses that are for cosmetic purposes.
4. Charges for hearing exams, hearing screenings, hearing aids and the fitting or repair or replacement of hearing aids, except as specifically provided.
5. Expenses incurred as a result of an Injury due to participation in a riot or attempt to commit a felony. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order. "Riot" means a public and violent disturbance of the peace by three (3) or more persons assembled together.
6. Expenses incurred due to an accident as a 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 commercial airline maintaining regular published schedules on a regularly established rout.
7. Expenses incurred due to an injury or illness as a result of working for wage or profit, or for which benefits are payable under any Worker's Compensation or Occupational Disease Law, Public Assistance Program, or Occupational Benefit Plans.
8. Expenses incurred as the result of an illness contracted or injury sustained while in service of the Uniformed Services of any country. Upon the covered person entering the Uniformed Services of any country a Covered Person may terminate their participation in this plan and request a pro-rated refund of premium.
9. Expenses incurred in a government hospital unless there is a legal obligation to pay.
10. Expenses incurred for care or services to the extent the charge would have been covered under Medicare Part A or B even though the covered person is eligible, but did not enroll in Part B.
11. Expenses incurred by a Covered Person who is not a citizen of the United States for services performed within the home country of that Covered Person.
12. Expenses incurred for breast reduction, mammoplasty and cosmetic or reconstructive surgery or other services and supplies which improve, alter, or enhance appearance. This exclusion does not apply to reconstructive surgery to implant a prosthetic device for a covered person who has undergone a mastectomy occurring while covered under this plan; reconstructive surgery required as the result of a birth defect, accidental injury or a malignant disease process or its treatment.
13. Expenses incurred that may be covered or recoverable under any other valid and collectible medical, health, motor vehicle or accident insurance plan; payable pursuant to a judgment or settlement by any person deemed responsible for the Injury or Illness (or their insurers); to the extent payable whether or not a judgment is delivered, or claim is made for such benefits.
14. Expenses incurred by a covered person after the date coverage terminates, except as may be specifically provided in the extension of benefits provision.
15. Expenses incurred for services rendered: by a person or individual acting beyond the scope of his or her legal authority; a member of the Covered Person's Immediate Family; or anyone who lived with

the Covered Person. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sport for which benefits are paid under another Sports Accident policy issued to the Policyholder; or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletic (NAIA) or any other sports association in excess of \$2,500 per accident.

16. Expenses incurred for procedures that are determined to be experimental or investigational.
17. Expenses incurred for Custodial Care.
18. Expenses incurred for the removal of an organ from a Covered Person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to donation by a Covered Person to a spouse, child, brother, sister or parent.
19. Expenses incurred for surgical or restrictive procedures for weight loss, except as specifically provided.
20. Expenses incurred for gynecomastia (male breasts).
21. Expenses incurred for any sinus surgery except for purulent sinusitis.
22. Expenses incurred to rent or buy personal hygiene/convenience items (such as air conditioners, humidifiers, hot tubs, whirlpools, general exercise equipment, telephones, TV, radio, extra bed/cot, guest meal, take home items, motorized transportation equipment, escalators or elevators in private homes, swimming pools or related supplies); standby charges of a physician; charges for missed appointments; photocopies of medical records; completion of forms; or expenses not medically necessary to diagnose or treat an Injury or Illness including but not limited to services related to the activities of daily living.
23. Expenses incurred for the use of braces, orthotics, or appliances unless used exclusively to promote healing or replace a body part, except as specifically provided.
24. Expenses incurred that were: not recommended by the attending physician; non-medical in nature; not required for the care and treatment of a covered injury or illness; in excess of Reasonable and Customary.
25. Expenses incurred for the treatment of Covered Students who specialize in the mental health care field, who receive treatment as part of their training in that field.
26. Expenses incurred for legend vitamins, food supplements, biological sera, blood plasma, drugs to promote or stimulate hair growth, experimental drugs, drugs dispensed in a rest home or hospital for take home usage, except as specifically provided.

## **COORDINATION OF BENEFITS / OTHER COVERAGE**

## **SECTION VIII**

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one (1) Plan. Plan is defined below.

### **A. MAXIMUM BENEFITS UNDER ALL PLANS**

If any *Covered Person* covered under the SHBP is also covered under one or more Other Plan(s), and the sum of the benefits payable under all the plans exceeds the *Covered Person's* eligible charges during any claim determination period, then the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under the SHBP. Benefits payable under another plan are included, whether or not a claim has been made. For these purposes,

- (1) claim determination period means a *Plan Year*; and
- (2) eligible charge means any necessary, *Reasonable and Customary* item of which at least a portion is covered under the SHBP but does not include charges specifically excluded from benefits under the SHBP that may also be eligible under any Other Plans covering the *Covered Person* for whom the claim is made.

### **B. OTHER PLANS**

Other Plan means the following plans providing benefits or services for medical and dental care or treatment and include:

- (1) group insurance or any other arrangement for coverage for *Covered Persons* in a group, whether on an insured or uninsured basis.
- (2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations (HMOs), *Medicare*, or Medicaid; or
- (3) no-fault automobile insurance (for purposes of the SHBP, in states with compulsory no-fault automobile insurance laws, each *Covered Person* will be deemed to have full no-fault coverage to the maximum available in that state. The SHBP will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the *Covered Person* is in compliance with the law, or whether or not the maximum coverage is carried).

### **C. DETERMINING ORDER OF PAYMENT**

If a *Covered Person* is covered under two or more plans, the order in which benefits will be determined is as follows:

- (1) The plan covering the *Covered Person* as a subscriber pays benefits first. The plan covering the *Covered Person* as an *Eligible Dependent* pays benefits second.
- (2) If no plan is determined to have primary benefit payment responsibility under (1) above, then the plan that covered the *Covered Person* for the longest period has the primary responsibility.
- (3) A plan that has no Coordination of Benefits provision will be deemed to have primary benefit payment responsibility.
- (4) The plan covering the parent of the *Eligible Dependent* child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the calendar year. The plan covering the parent of an *Eligible Dependent* child pays second if the parent's birthday falls later in the calendar year.
- (5) In the event that the parents of the *Eligible Dependent* child are divorced or separated, the following order of benefit determination applies:
  - (a) the plan covering the parent with custody pays benefits first.
  - (b) if the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second.

- (c) if the parent with custody has remarried, then the plan covering the stepparent pays benefits second, and the plan covering the parent without custody pays benefits third; and
- (d) if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

**D. FACILITATION OF COORDINATION**

For the purpose of Coordination of Benefits, the Claims Administrator:

- (1) may release to, or obtain from, any other insurance company or other organization or individual any claim information, and any *Covered Person* claiming benefits under the SHBP must furnish any information that the Plan Administrator may require.
- (2) may recover on behalf of the SHBP any benefit overpayment from any other individual, insurance company, or organization; and
- (3) has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the SHBP have been made by such organization.

**Special Provision for National Collegiate Athletic Association (NCAA)-Sanctioned Intercollegiate Sports**

Benefits for services related to participation in the University's NCAA-sanctioned intercollegiate sports are only provided by the Student Plan on a secondary payor basis. This provision does not apply to expenses incurred from the practice or play of intramural or club sports, as such expenses are covered on the same basis as if the injury were sustained in any way other than through participation in intercollegiate sports.

The Student Plan provides benefits for injury or illness resulting from the practice or play of NCAA-Sanctioned Intercollegiate Sports when:

- 1. Any maximum limits of insurance coverage provided by the NCAA are reached; or
- 2. A specific limitation or exclusion in NCAA coverage, or any other coverage provided by the University's Athletic Department for medical expenses incurred from practice or play of intercollegiate sports is applied to an expense that is otherwise eligible under the Student Plan.

In combination with NCAA and any other insurance/benefits provided by the University's Athletic Department, this provision assures that intercollegiate athletes do not incur any out-of-pocket expense resulting from the practice or play of NCAA-sanctioned intercollegiate sports that are greater than had the injury been sustained in any other way.

**Conditions Precedent to Coverage**

The SHBP shall have no obligation to pay benefits for a Covered Person if the Covered Person refuses to cooperate with the Claim Administrator's subrogation rights or refuses to execute and deliver such papers or information as the Plan Administrator may require in attempting to execute the plans' rights. Additionally, in the event the Covered Person is a minor, the SHBP shall have no obligation to pay for Covered Medical Expenses incurred due to a condition caused by a responsible third party until after the legal representative of that minor obtains a valid court order recognition and approval of the plans right to first dollar reimbursement and subrogation rights on all recoveries, and any documentation needed for the enforcement thereof.

**Right of Subrogation and Refund**

The SHBP shall have the right to be subrogated to any potential claim the Covered Person may have against any other entity whether or not the Covered Person chooses to pursue that claim. Please see the section on Subrogation as listed in the table of contents for more details.

This plan provides for Covered Medical Expenses of the Covered Person only while their coverage under the SHBP is in force. Except as provided in the Extension of Benefits provision, this SHBP will pay no benefits incurred after the Covered Person's coverage ends.

**A. Termination of coverage**

Coverage for a Covered Person will end on the first of the following:

1. The last day for which the required premium has been paid.
2. The date the Student withdraws from UMass Amherst because of returning to their home country or entering the Armed Forces of any country on an active-duty basis. Students entering the Armed Services may be eligible for a pro-rata refund of their premium if they submit a request for such in writing within 90 days of withdrawal from the University.
3. The last day of the plan year.
4. The date the SHBP terminates.
5. The end of the term for which premium has been paid in which the Covered Person no longer qualifies as a person eligible for SHBP coverage. Such people include:
  - a. A Student who is no longer eligible for coverage.
  - b. A Child who no longer qualifies as a dependent of a covered student.
  - c. A Former Spouse, who due to the marriage being annulled or divorce decree being granted, no longer qualifies as an eligible dependent of the Covered Student (unless Student is required by a court order spousal support agreement to provide medical coverage to an ex-spouse for a designated amount of time, not to exceed Student's eligibility requirements).
  - d. An individual who no longer qualifies as a Domestic Partner; or
  - e. A Dependent over the age of 26 is no longer reliant on the Covered Student for support.

Termination of coverage will not have any impact on a claim for covered medical service incurred prior to the end of coverage.

**B. Extension of Benefits**

If, on the termination date, a Covered Person is confined to a hospital due to a Covered Injury or Sickness, charges for that confinement will continue to be honored for a period of ninety (90) days following termination of insurance. Charges for medical expenses incurred within that time frame will not be covered if not related to the injury or illness causing the need for hospital confinement.

**C. Certificate of Creditable Coverage**

In the event a Covered Person loses coverage under the SHBP, the Plan Administrator will provide a Certificate of Coverage to the individual no longer covered by the SHBP. As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such Certificate of Coverage must be requested within 24 months of the Covered Person losing coverage under the SHBP.

**D. Medical Leave of Absence.**

Coverage will continue under the Plan for covered Students who take an approved Medical Leave of Absence on or after the first day of fall or spring classes until the first to occur of: (a) the last day of the coverage period for which the required premium was paid; or (b) the last day of the Plan Year. Thereafter, Students that remain on an approved Medical Leave of Absence following the first to occur of: (a) the last day of the coverage period for which the required premium was paid; or (b) the last day of the Plan Year. Students will need to complete an enrollment form at UHS with the patient Services Department.



**COMPLIANCE WITH HIPAA PRIVACY STANDARDS.**

In order to perform series in connection with the administration of the SHBP, certain individuals must have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these individuals are permitted to have such access subject to the following:

- (1) General.** The Plan shall not disclose Protected Health Information to anyone unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.
- (2) Permitted Uses and Disclosures.** Protected Health Information disclosed shall be used or disclosed only for purposes of administering the SHBP. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training, or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management, and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.
- (3) Authorized Individuals.** The Plan shall disclose Protected Health Information only to individuals, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "individuals" members of the Employer's workforce" shall refer to all persons or entities the Plan Administrator utilizes to administer the benefits of the SHBP.
  - (a) Updates Required.** The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.
  - (b) Use and Disclosure Restricted.** An authorized individual who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
  - (c) Resolution of Issues of Noncompliance.** In the event that any individual uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:
    - (i)** Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
    - (ii)** Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment.
    - (iii)** Mitigating any harm caused by the breach, to the extent practicable; and

- (iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
- (4) Certification of the Plan Sponsor.** The Plan Sponsor must provide certification to the Plan that it agrees to:
- (a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law.
  - (b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information.
  - (c) Not use or disclose Protected Health Information for performance-related actions and decisions or in connection with any other benefit or benefit plan of the Plan Sponsor.
  - (d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law.
  - (e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards.
  - (f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards.
  - (g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards.
  - (h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards.
  - (i) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and
  - (j) Ensure the adequate separation between the Plan and member of the Plan Administrator's staff, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

**COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS.** Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan Administrator agrees to the following:

- (1)** The Plan Administrator agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Plan Sponsor creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.
- (2)** The Plan Administrator shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.
- (3)** The Plan Administrator shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance with HIPAA Privacy Standards provisions (3) Authorized Individuals and (4) Certification of Plan Sponsor described above.

**A. Payment Condition**

- (1) In the event an Injury, Illness, disease, or disability is caused, in whole or in part, by or results from, the acts or omissions of the Covered Person or a third party, where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other policy or funds is available for payment of Covered Medical Expenses, the SHBP may elect, but it not required to conditionally advance payment of medical benefits.
- (2) By accepting benefits under the SHBP, a Covered Person recognizes the property right or equitable interest of the SHBP in any cause of action the Covered Person may have and the proceeds thereof up to and including the full extent of payment from any one or combination for first (1<sup>st</sup>) and third (3<sup>rd</sup>) party sources.
- (3) In the event of a settlement causing the Covered Person to receive a benefit form a third party or other coverage, the Covered Person acknowledges that the SHBP has the first priority right of recovery against such settlement and agrees to reimburse the SHBP for all benefits paid, or that will be paid. This includes first lien to the extent of benefits paid by the SHBP. Failure of a Covered Person to reimburse the SHBP for benefits provided or to be provided out of a judgment or settlement received, will be responsible for any and all collection expenses the SHBP must incur in attempting to recover such money from the Covered Person.

**B. Subrogation**

- (1) As a condition of receiving benefits under the SHBP, the Covered person agrees to subrogate the SHBP to any and all claims, causes of action or rights that may arise against any person, entity, or corporation and to any coverage for which the Covered Person may claim an entitlement regardless of how such entitlement is characterized or classified. The Covered Person agrees, as a condition of receiving benefits under the SHBP, that at the time such settlement or judgment is made, the SHBP will be reimbursed for any benefits relating to such settlement, paid on behalf of the Covered Person.
- (2) In the event the Covered Person chooses to pursue a third-party action or any coverage as available because of an Injury, Illness, Condition or aggravation of Condition, said Covered Person agrees to include the SHBP as subrogated to that action.
- (3) The SHBP may, in its own name or in the name of the Covered Person, their Beneficiary, personal representative, or legal counsel commence a proceeding or pursue a claim against such other party or coverage for recover of all expenses and damages to the full extent of the value of any benefits payable or advanced by the SHBP.
- (4) The Covered Person authorizes the SHBP to sue, pursue, settle or compromise, any such claims in their name and agrees to fully cooperate with the SHBP in prosecution of any such claims. This includes the Covered Person's failure to pursue damages or file a claim against:
  - a. Any policy of insurance from any insurance company or guarantor of a third party;
  - b. Any worker's compensation or other liability insurance company;
  - c. The responsible party, their insurer, or any other source on behalf of that party;
  - d. Any first party insurance no-fault coverage, personal injury protection, medical payment coverage, underinsured/uninsured motorist coverage; or
  - e. Any other source, including but not limited to restitution funds for crime victims, school insurance coverage, any medical, disability, or other benefit payments.

**NOTE:** the Covered Person, his or her guardian, or estate, assigns all rights to the SHBP or its assignee to pursue a claim and the recovery of all expenses from any source deemed applicable.

### **C. Right of Reimbursement**

- (1) The obligation of the SHBP being entitled to recover 100% of payment for Covered Medical Expenses exists, regardless of how any judgment or settlement is classified. At no point will the amount payable to the SHBP be reduced by attorney's fees, and costs, or application or the common fund doctrine, or the make whole doctrine, the Rimes Doctrine, or any other similar legal theory, and without regard to whether the Covered Person is fully compensated by his or her net recovery from all sources.
- (2) The SHBP will not pay any court costs, expert's fees, filing fees, expenses of a litigious nature, attorney fees, costs, expenses, or other expenses incurred by an attorney for the Covered Person or his/her beneficiaries. Any costs that cause the SHBP to recover less than 100% of the payment made for Covered Medical Expenses must be approved by the SHBP in writing in advance of the payments being made.
- (3) Furthermore, the Covered Person is prohibited from settling a claim against a third party or any other coverage for a portion of the damages but eliminating damages for Covered Medical Expenses.
- (4) The SHBP's rights are primary. As such said rights will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, under any "lien reduction statutes" such as the doctrine of causation, comparative fault contributory negligence, or any other similar doctrine of law.
- (5) The SHBP's rights of subrogation shall apply without regard to any separate written acknowledgement of these rights by the Covered Person.
- (6) Other remedies provided to the SHBP by law, shall not be limited by this provision.
- (7) The location of the event that led to or caused the need for subrogation will have no effect on this subrogation provision.

### **D. Excess Insurance**

If at the time of the event, there are other insurance or other sources of indemnification, this plan is excess to:

- (1) Any policy of insurance from any insurance company or guarantor of a third party;
- (2) Any worker's compensation or other liability insurance company;
- (3) The responsible party, their insurer, or any other source on behalf of that party;
- (4) Any first party insurance no-fault coverage, personal injury protection, medical payment coverage, underinsured/uninsured motorist coverage; or
- (5) Any other source, including but not limited to restitution funds for crime victims, school insurance coverage, any medical, disability, or other benefit payments.

### **E. Wrongful Death Claims**

Even if a Covered Person dies as the result of his or her Injury, illness, disease, or disability, the SHBP's right of Subrogation and Reimbursement will still apply.

### **F. Obligations**

It is the obligation of the Insured to:

- (1) Cooperate with the SHBP, or any of its representatives, in protecting the subrogation rights of the SHBP including completing discovery, attending depositions, cooperating in a trial, and all other actions taken in good faith effort by the representatives of the SHBP;
- (2) Not settle, without the prior consent of the SHBP, any claim that may involve the subrogation rights of the SHBP;

- (3) Do nothing to prejudice the SHBP's rights of subrogation and reimbursement;
- (4) Provide the SHBP with pertinent information including accident reports, settlement information and any other requested information;
- (5) Execute such documents and take such actions as the SHBP may require for facilitation of its enforcement of its subrogation and reimbursement rights;
- (6) Promptly reimburse the SHBP when recovery through settlement judgment award of other payment is received; and
- (7) Not release responsibility of any entity, party, person, fund, corporation, or insurance company or policy that may be responsible without prior written approval from the SHBP.

**NOTE:** Failure of the Covered Person, or entity legally representing them, to comply with any of these requirements may, at the SHBP's discretion, result in a forfeiture of payment for medical benefits. Any funds held by the University will be used to satisfy the Covered Persons obligation to the plan.

#### **G. Minor Status**

- (1) In the event the Covered Person is a minor, as that term is defined by applicable law, the minor's parent(s) or court-appointed guardian or estate shall cooperate in any and all actions requested by the SHBP to seek and obtain any requisite court approval in order to bind the minor and his or her estate insofar as the subrogation and reimbursement provisions are concerned.
- (2) If those legally responsible for the Covered Person who is a minor fail or refuse to take action, the SHBP will not be obligated to advance payment of medical benefits on behalf of the minor. Any legal fees or court costs for obtaining such approval shall be paid by those legally responsible for the minor.

#### **H. Language Interpretation**

The Plan Sponsor has charged the Claim Administrator with the responsibility for creating and maintaining all documentation relating to the establishment and operation of the SHBP. As such, the Claim Administrator has the sole right and responsibility to interpret the language of this provision, determine all questions of law and fact arising under this provision, and administer the SHBP's subrogation rights. Amendments may be implemented at any time, without prior notice. Please see the amendment and termination section as listed in the table of contents for more details.

#### **I. Severability**

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and the SHBP. The affected section shall be fully severable. The SHBP shall be construed and enforced as if such invalid or illegal sections had never been inserted in the SHBP.

#### **J. Act or Omission of Another**

If, due to any act or omission of another person or entity, a Covered Person suffers a loss that results in benefits for medical expenses being covered under this plan, the SHBP will be subrogated on any claim against such person or entity. As such, the Claims Administrator, on behalf of the SHBP, may exercise your right to recovery from the person(s), entity, or its designated insurance organization responsible for your loss. This Subrogation right permits the Claims Administrator, on behalf of the SHBP, to pursue any potential claim the Covered Person may have against any other entity whether or not the Covered Person chooses to pursue that claim.

The SHBP is entitled to any monetary recovery up to the amount of benefits provided under this SHBP for any Covered Medical Expenses. The rights of the SHBP are a first priority claim against all parties with a potentially fiduciary responsibility and are to be paid before any other portion of the Covered Person's claim. This is true no matter where or by whom the recovered money is held or how it is designated. The SHBP is entitled to a full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, regardless of whether the settlement or judgment received by the Covered Person identifies medical benefits provided by this plan. This includes payments described as 'other than health care expenses', 'pain and suffering', or 'non-economic damages only' even if the Covered Person does not recover the total amount of their claim against the other entity.

The amount the Covered Person reimburses will not be reduced by any fees for litigation, claim handling, or claim filing. The SHBP is not required to participate in or pay fee to the attorney hired by the Covered Person to pursue the Covered Person's claim. However, the SHBP will be responsible for fees for an attorney retained by the SHBP.

## DEFINITIONS

## SECTION XII

**Accident:** means a sudden specific event that is unforeseen, caused by an external force not due in whole or in part to a sickness or disease of any kind that is the direct cause of a physical injury occurring while the SHBP is in force as to the Covered Person.

**Actual Charge:** means a charge made for a covered medical expense by the practitioner who furnished the covered medical service.

**Adverse Benefit Determination:** means a notice provided by the Claim Administrator that medical care received does not meet the criteria for a Covered Medical Expense and is therefore not payable in whole or in part by the SHBP.

**Aggregate Maximum:** means the greatest amount of benefit that will be paid under the SHBP for a Covered Medical Expense incurred by a Covered Person during a Plan Year.

**Ambulatory Surgical Center:** refers to a freestanding ambulatory surgical facility that:

- Meets the licensing standards for its region and scope of practice.
- Keeps a medical record on each patient and charges for its services
- Is directed by a staff of physicians directly responsible for overseeing care of patients.
- Provides an ongoing quality assurance program that includes review of care by physicians who do not have a financial interest in the facility.
- Is set up, equipped and run to provide general surgery but does not have a place for patients to stay overnight but does have at least two (2) operating rooms and one (1) recovery room staffed by skilled nursing services directed by a Registered Nurse.
- Provides or has an arrangement with a local facility to provide x-ray, diagnostic testing, and lab services.
- Extends surgical staff privileges to local physicians who practice surgery and dentist who perform oral surgery.
- When surgery is being performed and during the recovery period, has: a physician, an anesthesiologist and staff trained and equipped to handle medical emergencies.
- Is equipped with: a blood volume expander, a defibrillator, a tracheotomy set, and a physician trained in Cardiopulmonary resuscitation; and
- Has a written agreement with a local hospital with emergency services to whom, in an emergency, care for said patient can be transferred. The procedure for transfer of care must be clearly documented, staff must be trained on such procedures, and the procedures themselves must be posted in a location documented in the staff's training.

**Appeal:** means a request that a decision to deny benefits be reviewed. Such review would include consideration of any relevant information.

**Birth Center:** refers to a freestanding facility that:

- Meets the licensing standards for its region and scope of practice;
- Keeps a medical record on each patient/child and charges for its services;
- Is directed by a staff of physicians directly responsible for overseeing care of patients. At least one of which specializes in obstetric and gynecologic care;
- Provides an ongoing quality assurance program that includes review of care by physicians who do not have a financial interest in the facility;
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care, accepts only patients with low risk pregnancies, and has a physician or certified nurse midwife trained to handle medical emergencies present at all births and during the immediate postpartum period with care provided on a full-time basis;

- Has at least 2 beds or birthing rooms for use by patients while in labor and during delivery with the ability to administer a local anesthetic and to perform minor surgery such as episiotomy and repair of perinatal tear;
- Provides or has an arrangement with a local facility to provide diagnostic testing and lab services for the mother and child;
- Extends staff privileges to local physicians who practice obstetrics and gynecology; and
- Has a written agreement with a local hospital with emergency services to whom, in an emergency, care for said patient or child can be transferred. The procedure for transfer of care must be clearly documented, staff must be trained on such procedures, and the procedures themselves must be posted in a location documented in the staff's training.

**Brand Name Prescription Drug:** means a medication that is protected by a trademark registration and only available by a written order by a physician.

**Certificate of Coverage:** means written documentation provided by the source of a Covered Person's medical insurance that confirms the duration and type of a Covered Person's creditable coverage. This can include the SHBP and or the Covered Person's prior carrier.

**Coinsurance:** means the out-of-pocket expenses to be paid by the Covered Person as a percentage of the Covered Medical Expenses as show in the Schedule of Medical Benefits.

**Complications of Pregnancy:** means a condition which requires advanced care such as a hospital stay before the pregnancy ends and whose diagnosis are distinct from but are caused or effected by the pregnancy. Such conditions include but are not limited to: cardiac decompensation or missed abortion, acute nephritis or nephrosis, non-elective cesarean section, termination of an ectopic pregnancy, medically necessary spontaneous termination of the pregnancy when a live birth of the child is not medically possible or a condition similar to those mentioned. Conditions that are not medically distinct from a difficult pregnancy are not considered a complication of pregnancy. Such conditions include but are not limited to: hyperemesis gravidarum, preeclampsia, morning sickness, false labor, occasional spotting, and physician prescribed rest period during a pregnancy.

**Congenital Condition:** means a condition, whether diagnosed or treated and regardless of the cause, which has existed since the birth of the Covered Person.

**Co-payment (Co-pay):** means a fee charged to the Covered Person at the point the service is rendered or prescription is dispensed.

**Coverage Period:** means the time(s) within a plan year that a Covered Person is covered. This is often the same as the plan year, but under certain circumstances and for certain Covered Persons may not be.

**Covered Medical Expense:** means charges for medically necessary treatment, services, or supplies received by an individual while enrolled in this plan. Covered charges may not be in excess of Preferred Allowance, Negotiated Fee, Reasonable and Customary expenses or in excess of charges that would be made in the absence of this insurance. Such expenses will be subject to the terms listed in the schedule of benefits and detailed in the covered benefits section.

**Covered Person:** means an individual that is covered under this plan as either the Covered Student or as an eligible Dependent of the Covered Student.

**Covered Student:** means a student of The Plan Sponsor who has paid the applicable premium for coverage and is enrolled in the SHBP.



**Creditable Coverage:** means health insurance coverage under any of the following:

- Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; 10 U.S.C. chapter 55;
- Part A or Part B of Title XVI II of the Social Security Act;
- A state health benefits shared risk pool;
- A health plan offered under 5 U.S.C. chapter 89;
- A group health plan;
- A health benefit plan under the Peace Corps Acts, 22 U.S.C. 2504;
- A public health plan as defined in federal regulations authorized by the Public Health Service Act, section 2701 (c)(1)(I), as amended by P.L. 104-191;
- A medical and dental care for members, or former members of the Armed Services;
- A health plan, including, but not limited to, a health plan issued, renewed or delivered within or without Massachusetts to a natural person who is enrolled in a qualifying student health insurance program pursuant to M.G.L. c. 15A, 18 or a qualifying student health program of another state; or
- A medical care program of the Indian Health Service or of a tribal organization.

Creditable coverage does not include accident only coverage; disability income; Medicare supplement; long-term care (LTC) insurance; dental or vision coverage issued as a supplement to liability insurance; payments made under an automobile plan; insurance held due to worker's compensation or other such occupational disease law; or any other such liability insurance required by statute.

**Custodial Care:** means care designed to assist a Covered Person with the activities of daily living, whether disabled or not, furnished without respect to the practitioner that prescribed, recommended or performed said activities. 'Activities of daily living' include but are not limited to personal care such as getting in or out of bed, walking, assistance in bathing or using the toilet, dressing, meal preparation, feeding, and planning and taking of medication accurately on a timely basis.

**Day Treatment/Partial Hospitalization** (when used in reference to mental health): means care greater than two (2) hours but less than twenty-four (24) hours per day for care in an individual or group basis in either a rural health center, community mental health center, substance abuse treatment facility, or licensed Hospital.

**Deductible:** means the dollar amount of Covered Medical Expenses that the Covered Person must incur as an out-of-pocket expense each Policy Year before benefits are payable under this Policy. The Deductible amount, as shown in the Schedule of Medical Benefits, may be reduced or waived under certain conditions. Most of such conditions are specified in the Schedule of Medical Benefits.

**Durable Medical Equipment (DME):** means no more than one (1) item of equipment used for the same or similar purpose, the accessories needed to operate it, and/or the repair, maintenance, replacement and adjustment of said equipment, that is:

- Not for exercise or training;
- Not for use in altering air quality or temperature;
- Made for and mainly used in the treatment of a disease or injury;
- Not normally of use to a person who does not have said disease or injury;
- Not merely for convenience or independence such as phone alerting systems, massage devices, over bed tables, communication aids, or other such item;
- Suited for use in the home; and

- Made to withstand prolonged use.

Equipment such as: over-bed tables, elevators, communication aides, telephone alert systems, portable whirlpool pumps, sauna baths, whirlpools, and massage devices do not meet the definition of DME.

**Effective Date:** means the time the Covered Person's coverage Period begins. This is often the beginning of the plan year, but under certain circumstances and for certain people may not be.

**Effective Treatment of Addiction/Substance Abuse:** refers to a treatment program that is more than just providing an environment without access to substances that meets all of the following:

- Is prescribed for a Covered Person by a qualified physician;
- Is supervised by a qualified physician;
- The written care plan created by the treating physician requires establishment of at least monthly follow-up care in either a group or individual therapy program; and
- Attendance at least two (2) times a month at meetings of organization devoted to the treatment of addiction.

**Eligible Dependent:** means one of the following persons:

- (1) A child of the Covered Student who has not attained 26 years of age;
- (2) A person who is the lawful spouse of the Covered Student;
- (3) A person for whom the covered student has completed and signed a "declaration of domestic partnership";
- (4) An unmarried child of the person who has attained 26 years of age, but is permanently and totally disabled (as defined by Internal Revenue Code Section 22 (e)(B)).

For purposes of determining eligibility, the term child includes:

- An individual under age 26 for whom the Student is required to provide coverage due to a Qualified Medical Child Support Order;
- A child for whom legal guardianship has been awarded to the Student.
- A legally adopted child;
- A child placed with the Student for adoption by a court with adequate jurisdiction;
- A stepchild by legal marriage; or
- A biological child of the Student.

**Elective Treatment:** means medical treatment that is not made medically necessary by a pathological change in the structure or function in any part of the body occurring after the Covered Person's effective date of coverage. Treatment considered elective includes, but is not limited to:

- Breast reduction (except as needed following cancer treatment to create a symmetrical appearance);
- Temporomandibular joint dysfunction (TMJ);
- Treatment of infertility;
- Sub-mucous resection and/or other surgical correction for deviated nasal septum other than treatment of covered acute purulent sinusitis; and
- Weight reduction (other than counseling under mental health).

**Emergency Medical Condition:** means medical condition that manifests itself by symptoms of sufficient severity, that could lead a reasonably prudent layperson with an average knowledge of health and medicine, to believe that lack of prompt medical attention could place the health of a Covered Person in serious jeopardy, serious impairment to body function, serious dysfunction of any body organ or part, or, with respect to a pregnant woman, may cause distress to the fetus.

**Emergency Medical Care:** means immediate medical intervention to prevent death or serious impairment of the health of the Covered Person.

**ERISA:** means the Employee Retirement Income Security Act of 1974, and all of its applicable amendments.

**Experimental/Investigational** – means a drug, device, medical treatment, new technology, procedure, or supply, which is not recognized as a Covered Medical Expense as follows:

- (1) The drug 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, device, treatment, new technology, procedure, or supply is furnished.
- (2) The drug, device, medical treatment, new technology, procedure, or supply, or the patient's informed consent document utilized with the drug, device, treatment, new technology, procedure, or supply, 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.
- (3) Reliable evidence shows that the drug, device, medical treatment, new technology, procedure, or supply is the subject of on-going Phase I or Phase II clinical trials; is the research, experimental study, or investigational arm of on-going Phase III clinical trials; or is otherwise under study to determine its maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.
- (4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure, or supply is that further studies or clinical trials are necessary to determine maximum tolerated dose, toxicity, safety, or efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means 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, new technology, procedure, or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure, or supply.

**Generic Prescription Drug:** means a medication that is not protected by a trademark registration and only available by a written order by a physician.

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

- Certified as a home health agency by Medicare; or
- Licensed as a home health agency in the state where the home health care is being provided; and
- Certified as either by Wellfleet.

**Home Health Aide:** means a trained or certified professional that is not a family member of the Covered Person, who provides the Covered Person services through a home health agency in response to a care plan written, supervised, and directed by the treating physician. The professional is primarily there to aid the Covered Person in performing the normal activities of daily living while recovering from a covered medical condition.

**Home Health Care:** care provided to a Covered Person on a part-time, intermittent, visiting basis in the covered Person's place or residence while the Covered Person is confined as the result of a covered medical condition. Such in-home care must be certified by a physician to be in lieu of care in a hospital or skilled nursing facility.

**Home Health Care Plan:** means a plan of care established in writing by a treating physician, for continued care in a person's home. Such plan must be in lieu of care in a hospital or skilled nursing facility or follow within twenty-four (24) hours of a hospital confinement (for the same medical condition).

**Hospice:** means a program or facility that provides a coordinated program of home and inpatient care, including respite care, for terminally ill patients during the Hospice Benefit Period. Benefits provided by said program satisfy the special needs of a Covered Person during the final stages of a terminal illness. The program must meet any licensing requirements and the standards of the national Hospice Organization.

As used in this definition:

- **"Hospice Benefit Period"** means the date the treating physician certified that a Covered Person is terminally ill and has a diagnosis of less than 6 months to live. Such period ends on the date of death of the patient.
- **"Respite Care"** means care provided to give temporarily relief to the family or other care giver of a terminally ill Covered Person. This care is to be used in emergencies and for temporary relief from the daily demands of caring for a terminally ill Covered Person.

**Hospital:** means a health care facility that:

- Primarily engaged to provide in-patient services for a fee for the treatment of Injured and sick people;
- Has established facilities for diagnosis and major surgery under the supervision of a physician (s) who is(are) legally licensed to practice medicine;
- Is licensed and run as a hospital according to the laws and regulations applicable to the location/jurisdiction including the Joint Commission on Accreditation of Health Care Organizations and accredited by the Commission of Accreditation of Rehabilitation Facilities.

**Hospital Confinement:** means a stay of eighteen (18) or more hours in a row of care as a patient in a hospital.

**Illness:** means a disorder or disease either of the body or a mental nervous disorder including reoccurring symptoms of the same illness. In this document the term Illness and Sickness are used interchangeably. All conditions due to the same or related illness are considered one illness. The term Illness/Sickness includes pregnancy, and complications of pregnancy.

**Incurred Date:** means the date the service was performed, or the supply was provided.

**Infertility:** means the condition of a presumably healthy individual who is unable to conceive or produce conception during a one-year period.

**Injury/Injuries:** means physical harm to the body due to an accident, trauma, or damage that includes complications arising from an injury due to an accident but is independent of all other causes including illnesses.

**In-Network:** means an organization, Hospital, Physician, Practitioner, or other Provider that has agreed to participate in the Preferred Provider Network and accept a Negotiated Charge for their services. That negotiated charge, known as the preferred provider amount (PA), is the maximum charged a provider in the network for their service or supply under this plan.

**Intensive Care Unit (ICU):** means a designated ward, unit, or area within a Hospital with a specified daily extra surcharge that is staffed and equipped to provide, on a continuous basis, specialized care not regularly provided within the main-stream inpatient units of the hospital.

**Medically Necessary:** means a service or supply that is not experimental or investigational and is necessary and appropriate for the diagnosis or treatment of an Injury or Illness based on generally accepted current medical practices.

For a treatment, service or supply to be considered medically necessary, the service or supply must, without creating a negative impact on the overall health of the Covered Person, be:

- Care or treatment likely to produce a significant positive outcome both to the sickness or injury involved and to the overall health of the Covered Person without being more costly than any other comparable care or treatment; or
- A diagnostic procedure likely to result in producing information that could affect the course of treatment in a way other less costly diagnostic procedures could not do; and
- Ordered by a treating physician; safe and effective in treating the condition for which it is ordered; of the proper quantity, frequency, and duration for the treatment of the condition for which it is ordered; and applied according to practices generally accepted by the American Medical Community.

In determining if a service or supply is appropriate under the circumstance, the Claim Administrator will take all pertinent information into account such as:

- Information relating to the health status of the Covered Person;
- Reports in peer reviewed medical literature;
- Reports and guidelines, including scientific data, published by nationally recognized health care organizations;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis care or treatment; and
- The opinion of health care professional in the generally recognized health field specifically involved.

Medically Necessary will never include: services that do not require the technical skills of a medical, mental health or dental professional; or service furnished mainly for the personal comfort or convenience of the Covered Person or any person who is caring for the Covered Person; services furnished solely because the person was inpatient on a day which their person's covered medical condition could safely and adequately be diagnosed or treated on an outpatient basis or other less costly setting.

**Medicare** means Title XVIII of the Social Security Act of 1965, as amended. Part A means Medicare's hospital plan and Part B means the supplementary medical plan.

**Mental Health Disorder** means a condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization, including, but not limited to, the diagnostic categories or sub-classifications of:

1. Schizophrenia and other psychotic disorders;
2. Bipolar disorders;
3. Depressive disorders;
4. Anxiety disorders; and
5. Anorexia and bulimia.

**Morbid Obesity:** means a diagnosed condition in which the body weight of the Covered Person exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age, and mobility as the Covered Person.

**Out-of-Network:** means an organization, Hospital, Physician, Practitioner, or other Provider that has not agreed to participate in the Preferred Provider Network.

**Out-of-Pocket:** means the most You will pay during a Policy Year before your coverage pays at 100%. This includes deductibles, copayments (medical and prescriptions) and any coinsurance paid by You. This does not include non-covered medical expenses and elective services.

**Partial Hospitalization** (other than when used in reference to mental health): means continuous treatment consisting of not less than four (4) hours but less than eighteen (18) hours in any twenty-four (24) hour day for care a program based in a hospital.

**Physician:** means a practitioner of the healing arts that is legally qualified and recognized by the state in which he or she practices. Such practitioners include but are not limited to: Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Licensed Anesthesiologist, Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed. D., Psy.D., MA), Registered Nurse (R.N.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Occupational Therapist, Physician's Assistant, Registered Respiratory Therapist, Nutritionist, Nurse Practitioner (A.R.N.P.), or Naturopath (N.D.).

**Plan Year:** means August 1 of a given calendar year through July 31 of the next calendar year.

**Preadmission testing:** means tests, ordered by a duly qualified Physician, related to the condition causing the need for an inpatient stay that are performed on an outpatient basis prior to confinement.

**Preferred Allowance:** means the amount a provider, contracted with the preferred provider network, has agreed to accept as payment in full for a Covered Medical Expense.

**Primary Care Physician (PCP):** means the preferred provider who is selected by the Covered Person to be the person responsible for the ongoing health care concerns of the Covered Person.

**Qualified Medical Child Support Order:** means a legal document requiring the Covered Person to provide medical coverage for his or her eligible Dependent. Said document will specifically state what is to be provided, when and for how long. Coverage for an eligible dependent will begin concurrently with the student at the beginning of the plan year, or, if the document is enacted in the middle of a plan year, the date specified in the support order.

**Reasonable and Customary Charges (R&C):** means most common charge for similar professional service, procedures, drugs, devices, supplies or treatment within the geographical area where the covered medical expense was incurred. The most common charge means the lesser of:

- The actual amount charged by the provider; or
- The negotiated rate; or
- The charge which would have been made by the provider (Doctor, Hospital, etc.) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by us for the same service or supply.

As used in this plan: "Geographic Area" means the three (3) digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

**Room and Board:** Means daily or weekly charges made by an institution for inpatient care other than necessary services and supplies.

**School Health Services:** means an organization, facility, or clinic operated, maintained, or supported by the school or other entity under contract to the school which provides health care services to enrolled students and their dependents.

**Semi-private Rate:** means the charge for room and board that an institution applies to care provided on an inpatient basis where there are more than one bed in the room.

**Sickness:** means either a disorder or disease of the body including reoccurring symptoms of the same illness. In this document, the term Illness and Sickness are used interchangeably. All conditions due to the same or related sicknesses are considered one sickness. The term Illness/Sickness includes pregnancy, and complications of pregnancy.

**Significant Break in Coverage:** means a period of sixty-three (63) consecutive days during all of which a Covered Person did not have any Creditable Coverage, but does not include waiting periods or affiliation periods.

**Skilled Nursing Facility:** means a lawfully operating facility engaged in the business of providing treatment for people recuperating from an injury or sickness. Said facility organized for medical services must:

- Have 24-hour nursing care provided by Registered Nurses;
- Keep records for each patient;
- Have a written agreement with an emergency care facility for care of its patients if needed;
- Have a capacity of six (6) or more beds;
- Have a physician available at all times; and
- Qualifies under Medicare as an extended care facility but is not, other than incidentally, a place for rest, for the aged, for the blind or deaf, or for the mentally ill/mentally handicapped.

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

**Student:** means a person who is matriculated at the University of Massachusetts Amherst. Please see the eligibility section for details.

**Substance Use Disorder** means any condition or disorder that substantially limits the life activities of an Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization. This does not include caffeine-related disorders and nicotine-related disorders.

**Surgical Assistant:** Means a medical professional trained to assist in surgery in both the pre-operative and postoperative period under the supervision of a physician.

**Totally Disabled:** means a Covered Person who is not able to engage in most of the normal activities of a person of similar age, gender and in good health due to a covered condition.

**Uniformed Service:** means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or fulltime National Guard duty; the commissioned corps of the Public Health Service; and any other category of persons designated by the President in the time of war or emergency.

**NOTE:** Throughout this document, the terms "Armed Services", "Armed Forces", and "Uniformed Service" are used interchangeably.

**Urgent Care Provider:** means a freestanding medical facility that:

- for a fee, provides unscheduled medical services to treat an urgent condition when the Covered Person's Primary Care Physician (PCP) is not available;
- Is licensed and certified within the laws of the state and region in which the facility operates; and
- Is run by a staff of physicians including one on call at all times.

**Urgent Condition:** means a sudden illness, injury, or change in condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the health of the Covered Person;
- Includes a condition which would subject the Covered Person to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in an emergency room or trauma center; and
- Requires immediate outpatient medical care that cannot be postponed until the Covered Person can be seen by their Primary Care Physician (PCP).

**Well Child Care:** means treatment that is in accordance with the standards and frequencies endorsed by the American Academy of Pediatrics. Covered Medical Services include, but are not limited to, physical examinations, history, sensory screening, developmental screening, and appropriate immunizations.

**We, Our or Us:** means the Claim Administrator on behalf of The University of Massachusetts Amherst SHBP.

**You, Your, Yours** means the Covered Person.

## **PROCEDURE/STATEMENT OF RIGHTS**

## **SECTION XIII**

### **A. Claims Procedures**

The investigation and adjudication of claims will be handled by the Claim Administrator. In order for the Claim Administrator to process claims:

1. Bills must be submitted within 90 days of the date of the covered medical expense.
2. Unless proof of prior payment is submitted, payment for covered medical expenses will be made directly to the provider.
3. Itemized medical bills, if available, should be attached and submitted along with the claim form.

Forward all Claims to:

**CIGNA**

PO Box 188061  
Chattanooga, TN 37422-8061

4. When the claim is processed, the Covered Person will receive an "Explanation of Benefits". Such explanation of benefits will explain how the claim was processed, according to the SHBP benefits.

A covered person must submit a benefit claim, and all attachments, within twelve (12) months of the date of service.

For Covered Medical Expenses subject to Precertification, please contact the Claim Administrator at:

Wellfleet Group, LLC  
PO Box 15369  
Springfield, MA 01115-5369  
[www.wellfleetstudent.com](http://www.wellfleetstudent.com)  
Customer Service: 877-657-5027



For details on the requirements of pre-certification, please see the Preadmission/ Precertification section as listed in the table of contents.

The Plan Sponsor had delegated the administration of claims processing under the SHBP to the Claim Administrator. The Claim Administrator has final authority to determine the amount of benefits that will be paid on any particular item.

In the event a Covered Person has filed a post-service claim for reimbursement of Covered Medical Expenses said person already paid, the Claims Administrator will only inform the Covered Person if the claim is denied in whole or in part. Such notification will be issued within thirty (30) days after the Claim is received by the Claims Administrator. If, due to matters beyond the control of the Claims Administrator, such notification cannot be issued within that thirty (30) daytime frame, an extension of up to fifteen (15) days may be granted. If additional information is requested, a Covered Person will have at forty-five (45) days to provide that information to the Claims Administrator.

## **B. Inquiry, Grievance and Appeals Process**

**Adverse Determination** means a determination by Us, based upon a review of information provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

**Inquiry** means any communication to Us by You or on Your behalf that has not been the subject of an adverse determination and that requests redress of an action, omission or policy of Ours.

**Internal Inquiry Process** is a process, prior to the Grievance process, during which We attempt to answer and/or resolve concerns communicated by You or on Your behalf to Your satisfaction. If We fail to answer Your questions or resolve Your concerns to Your satisfaction within three (3) business days, You have the option to proceed to the Internal Grievance process.

### **Inquiry Procedure:**

- (a) If You have an Inquiry You may call Wellfleet at 877-657-5027. We will try to resolve Your inquiry within three (3) business days.
- (b) If Our Administrator is unable to resolve Your concern to your satisfaction, You may, request an internal Grievance.

### **First Level Internal Grievance**

If You have received an Adverse Determination, denial of benefits, have a complaint or if You are not satisfied with the outcome of an Inquiry, You or a health care provider acting on Your behalf, may file a Grievance with Us, within 180 days, requesting a first level review. The request may be by telephone, in person, by mail or by electronic means. Any oral Grievance made by You will be reduced to writing by Us and a copy will be forwarded to You within 48 hours or receipt.

Within five (5) working days or receipt of Your Grievance, We will provide You with the name, address and telephone number of the person or organization designated to coordinate the first level review. The reviewers will take into consideration all comments, documents, and other information regarding the request for services submitted by You. You are entitled to provide additional written comments, documents, records and other materials relating to the request for benefits for the reviewers to consider when conducting their review. You are also entitled to receive from Us, upon request and free of charge, reasonable access to and copies of all documents, records and other information

relevant to You request for benefits as well as any new or additional rationale for denial and a reasonable opportunity for You to respond to such new evidence or rationale.

We will issue a decision to You within the time frames provided below:

- (a) With respect to a Grievance requesting a first level review of an Adverse Determination involving a prospective review request, We shall notify and issue a decision within a reasonable period of time that is appropriate given Your medical condition, but no later than thirty (30) days after the date of Our receipt of the Grievance requesting the first level review.
- (b) With respect to a Grievance requesting a first level review of an Adverse Determination involving a retrospective review request, We shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of Our receipt of the Grievance requesting the first level review.
- (c) With respect to a Grievance that does not involve an Adverse Determination, We shall issue a decision within twenty (20) days after the date of receipt of the Grievance requesting a review.

If You appeal, We will review our decision, as well as any additional comments, documentation, records and other information submitted by You, and provide You with a written determination. If We continue to deny the payment, coverage, or service requested or You do not receive a timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision.

#### **Second Level Internal Grievance (Optional)**

If You are unhappy with the First Level Internal Grievance decision, You have the right to an additional review. You or Your authorized representative may request a Second Level Internal Grievance review within 45 days from receipt of the decision by following the steps outlined above for the First Level Internal Grievance.

Your request will be reviewed by a panel, appointed by Us, which shall consist of individuals who were not involved in the first level review decision and shall take into consideration all comments, documents, records, and other information regarding the request for benefits submitted by You or Your authorized representative. You have the right to appear before this panel at the review meeting which will be held within forty-five (45) working days of the receipt of Your request. You will be notified at least fifteen (15) working days prior to the date of the review meeting. A written decision will be issued to You within five (5) working days of completing the review.

#### **Expedited Internal Grievance**

You or Your authorized representative may make a request, either orally or in writing, for an expedited internal review of an Adverse Determination involving an admission, availability of care, continued stay or if You have received Emergency services but have not been discharged from a facility. An expedited review decision will be made and You will be notified of the decision as soon as possible but in no event more than twenty-four (24) hours after receipt of the request for expedited review.

If the Grievance involves an Adverse Determination with respect to a concurrent review urgent care request, the service(s) in question will be continued until You have been notified of Our determination.

#### **External Review**

Under the Plan Sponsor's voluntary compliance with the Patient Protection and Affordable Care Act (PPACA), a request to the commissioner of insurance for the state of Massachusetts is not necessary.

You may request an External Review once You have exhausted Our Internal Grievance process or if You have elected not to pursue the Second Level Internal Grievance process. You shall be considered to have exhausted Our internal Grievance process, if You:

- (a) Have filed a Grievance involving an Adverse Determination; and
- (b) Except to the extent that You requested or agreed to a delay, have not received a written decision on the Grievance from Us within thirty (30) days following the date You filed the Grievance with Us.

### **Standard External Review**

If You are unhappy with the outcome of the Second Level Internal Grievance, or You have chosen not to pursue the Second Level Internal Grievance, You may request an External Review from Wellfleet Group, LLC. The request must be made within four (4) months of the date of an Adverse Determination. The request shall be sent to Wellfleet, PO Box 15369, Springfield, MA 01115-5369. You may also contact Wellfleet by telephone at 877-657-5027. Note: a nominal administrative fee may apply. Such fee may be waived if it is found that such fee will result in extreme financial hardship to the Covered Person or the party responsible for such Covered Person's finances.

### **Expedited External Review**

You or Your authorized representative may make a request, in writing, for an expedited external review to Wellfleet. The request shall contain a certification from a physician, stating that a delay in the providing or continuation of health care services that are the subject of the final adverse determination would pose a serious and immediate threat to Your health.

If Wellfleet finds that a serious and immediate threat to You exists, they shall qualify such request as eligible for expedited external review and shall promptly assign the request to an external review agency on a random basis. Wellfleet shall forward a copy of Your request, together with any related documentation to the external review agency.

### **Continuation of Services**

If the subject of the external review involves termination of ongoing services, You may apply to the external review agency for continuation of coverage for the terminated service while the review is pending. The request for continuation must be made before the end of the second business day following Your receipt of the final adverse determination.

The External review agency may order the continuation of coverage or treatment if it determines that substantial harm to Your health may result without the continuation or for any other good cause the review agency may find.

### **Final Determinations**

The final decision by the external review agency will be in writing and will set forth the specific reasons for the decision:

- (a) Within four business days from the receipt of the referral from the OPP for expedited reviews; or
- (b) Within 60 days from receipt of the referral from the OPP for non-expedited reviews.

The external review agency's decision shall be binding.

**PRINCIPLES OF SHBP**

THIS INSTRUMENT, has been established by the University of Massachusetts Amherst (hereinafter UMass Amherst, or The Plan Sponsor), to set forth the Undergraduate University of Massachusetts Amherst Student Health Benefits Plan (hereinafter SHBP).

**A. Establishment of SHBP.** The Plan Sponsor hereby sets forth its student health plan under the following terms and conditions.

- (1) The sole purpose of the SHBP is to provide health care benefits to Students of UMass Amherst covered by the Plan. Reserve SHBP funds are encumbered solely for the purpose of operating the SHBP.
- (2) If, upon the termination of the SHBP, there are reserve funds, such surplus funds will be exclusively used for educational services or health care services for the Student population of The University as determined by the Chancellor of the University of Massachusetts Amherst.
- (3) SHBP funds and SHBP reserve funds earn investment income and are not commingled with other University accounts. All SHBP funds are invested in accordance with policies established by the plan sponsor with earnings returned to the SHBP.
- (4) Plan provisions are published. The provisions of this document are the exclusive basis for administering the benefits of this plan. Please refer to: [www.wellfleetstudent.com](http://www.wellfleetstudent.com) for all documents pertaining to the program and/or assistance with other University policies as applicable.
- (5) Extra-contractual benefits must fit the following criteria, as determined by the Plan Administrator or his / her delegate:
  - a. Benefits must be medically necessary;
  - b. Must result in either cost savings for the plan, or significantly improved quality of care for the Covered Person with little difference in the amount of benefits that would have otherwise been paid by the plan.

The Plan Administrator must review and approve any extra-contractual benefits.

**B. Effective.** The effective date of the SHBP is August 1, 2022.

**C. General Provisions.** It is the intention of the SHBP to abide by the Provisions and Conditions as they are set forth in this document and, if needed, any applicable amendments that are attached and intended to be part of this document.

IN WITNESS WHEREOF, a duly authorized representative of the University of Massachusetts Amherst has executed the Student Health Benefit Plan (SHBP).

**University of Massachusetts Amherst**

\_\_\_\_\_  
Date

By: \_\_\_\_\_  
Authorized Signature

Title: \_\_\_\_\_

## **GENERAL PROVISIONS**

### **A. Plan Funding**

The SHBP shall pay benefits in cash from a fund established by the University, encumbered for the sole purpose of operating the SHBP. No person or entity shall have any title, right, or interest in or to any investment reserves, accounts of funds that may be purchased, established, or accumulated to aid in providing benefit under the SHBP. No single person or entity shall acquire any interest greater than that of an unsecured creditor.

### **B. In General**

Rights provided to the Covered Person under the SHBP are subject to the terms and conditions of the SHBP. At no point will any of the documents associated with the SHBP constitute a contract between The Plan Sponsor and the Covered Person. Enrollment in the SHBP does not positively or negatively impact the Student's right to become or continue to be a student at the University. No agreement between The Plan Sponsor and the Covered Person will be construed to give the Covered Person rights not specifically provided in the SHBP.

### **C. Non-Participating**

The SHBP is a non-participating plan. It does not share profits or earnings with any other entity up to and including the Plan Administrator. Reserve SHBP funds are encumbered solely for the purpose of operating the SHBP.

### **D. Severability**

If, for any reason, a provision of the SHBP shall be held invalid or illegal, any invalidity or illegality shall only affect that portion of the SHBP and not impact the remaining parts of the SHBP. The SHBP shall be enforced as if the section in question did not exist. The Plan Sponsor shall have the privilege and opportunity amend the SHBP if a correction is needed to settle a question of invalidity or illegality.

### **E. Contract Changes**

The SHBP, including any endorsements, amendments, or attached papers, constitutes the entire contract. Changes to the SHBP will not be valid unless approved in writing by one of the Executive officers of the Plan Administrator. Documentation of such must be attached to the SHBP. No agent had authority to change the SHBP or waive any of its provisions. Failure of the Plan Administrator to enforce any element of the SHBP shall not waive, modify, nullify, or render such element unenforceable. The Plan Administrator maintains discretionary authority to address all questions arising from the SHBP and interpretation of elements of the plan.

### **F. Information and records**

The Plan Sponsor will provide the Claim Administrator information needed for the administration of the plan. Such information includes when a Covered Person becomes covered, when changes in amounts of coverage occur, and when a Covered Person's coverage terminates.

### **G. Certificate of Insurance**

When required by law, the Plan administrator will furnish the individual Covered Person with a Certificate of Insurance. Such Certificate will outline the benefits provided by the SHBP.

**H. Nondiscriminatory**

The SHBP provides benefits to a Covered Person on a non-discriminatory basis.

**I. Notification**

The Plan Administrator will provide a Covered Person documentation of all material changes to the SHBP as needed.

**J. Legal Actions**

Legal actions may not be brought to recover against the SHBP more than three (3) years from the date a Proof of Loss was required to be given or within sixty (60) days after a written Proof of Loss as been given as required.

**K. Physical Examination and Autopsy**

The Claim Administrator, on behalf of the SHBP, retains the right and opportunity to examine the Covered Person as it may reasonably be required as pertaining to a pending claim. In the case of death, and where not prohibited by law, this may include the right to make an autopsy.

## **PLAN ADMINISTRATION**

### **A. Delegation of Authority**

The University of Massachusetts Amherst has established this SHBP for the benefits of its student population and has selected the Claim Administrator to govern this plan. As such The Plan Sponsor has delegated the following authority to the Claim Administrator at its sole discretion and exclusive right to:

- Construe and interpret the terms and provisions of the SHBP;
- Make determinations regarding issues which relate to eligibility for benefits;
- Decide disputes which may arise relative to the rights of the Covered Person; and
- Rule on questions of benefit interpretation and those of fact relating to the plan.

The decisions of the Claim Administrator will be final and binding on all interested parties.

### **B. Plan Administrator Duties and Powers**

The Plan Administrator will have the power and duty to:

- a. Establish, communicate, and enforce procedures, rules, regulations, forms, reporting structure, claim filing and payment procedures, disputes of claim denial, and all other elements necessary to the administration of the plan in accordance with the SHBP.
- b. To administer the SBHP in accordance with such rules including the right to interpret language and resolve any possible inconsistencies, omissions, or ambiguities.
- c. Keep and maintain all documents and records pertaining to the SHBP and perform any necessary reporting.
- d. Determine the amount of benefit the plan would be responsible for on a given claim, decide upon disputes regarding a Covered Person's rights and coverage and communicate that information to the Covered Person in response to an inquiry or denial of benefits in whole or in part.
- e. Review claims denials and decide on questions concerning a Covered Person's eligibility to participate in the SHBP, including determination of whether or not a Medical Child Support Order is applicable to the SHBP for a given Covered Person.
- f. As a condition of receiving benefits under the SHBP require a Covered Person to furnish information requested by the Plan Administrator as needed for proper administration of the SHBP.
- g. Delegate any person or entity such powers, duties, and responsibilities as it deems appropriate and necessary for the effective administration of the SHBP such as actuaries, accountants, consultants, third-party administration services, legal counsel, or other specialist.
- h. Appoint a Claim Administrator to pay claims.
- i. Designate other individuals or entities to perform duties that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator.
- j. Perform any other actions of functions that would normally be the responsibility of an administrator of a similar SHBP.

### **C. Plan Administrator Resources**

When appropriate for the administration of the SHBP, a Plan Administrator may engage the services of individuals or entities as an appropriate resource for the operations of the SHBP. This will include

the ability to retain the services of health care professional(s) or agencies for the purpose of claims appeals review.

The Claim Administrator may, in good faith, also rely on calculation and research tools furnished by an established resource, such as tables, valuations, certificates, reports and opinions or well-informed sources. The Plan Administrator is fully protected in respect to an action taken or decision made, based on such tools based on having made a good faith effort to act fairly and appropriately.

#### **D. Administrative Expenses**

The Claim Administrator serves the SHBP without direct compensation. However, all expenses for administration of the plan, including any hired services, research organizations, review organizations, Health Care Professionals, or any independent or group entity utilized in the administration of the SHBP, will be paid by the SHBP.

#### **E. Fiduciary Liability**

To the extent permitted by law, neither the Plan Administrator, Claims Administrator, nor any other person or entity will incur liability for any acts or failure to act.

For the purpose of this section a “Fiduciary” means an individual or entity that exercises discretionary authority or control over the management of the SHBP or the disposition of its assets.

A Fiduciary must make all reasonably good faith effort to carry out their duties with care, skill, prudence and diligence as would, under the given circumstances, a prudent person acting in a like capacity and familiar with such matters. Said Fiduciary should, unless it is clearly prudent to not do so, diversify the investments of the SHBP as to minimize the risk of a large loss whenever possible and in all things, act in such a way that defrays all reasonable expenses of administering the plan. It should be noted that the Claim Administrator is not a Fiduciary under the plan by virtue of paying claims in accordance with the rules of the SHBP as established by the Plan Administrator.

#### **F. Clerical Error**

The Plan Administrator, and any entity with delegated authority, will do their utmost to execute their duties with skill and accuracy. However, time to time, errors may occur. An error found will in no way invalidate coverage otherwise validly in force or reinstate coverage terminated for valid cause.

If an overpayment occurs due to a clerical error, the Plan retains a contractual right to be reimbursed for that overpayment. The person or entity receiving the overpayment will be required to remit the amount that was paid incorrectly. In the event such overpayment is made to the Covered Person, the plan reserves the right to deduct such overpayment from future benefits payable.

If, due to a clerical error, a member of an eligible class does not become enrolled as expected, coverage may be placed in effect if:

- a. The Plan Sponsor makes a written request for coverage on a form provided by the Plan Administrator.
- b. The request for coverage is received within two (2) months of the date the error was reported; and
- c. Any required premium not previously paid, is paid in full, from that person’s effective date.

Conversely, if an individual who is not eligible for coverage becomes enrolled in the SHBP due to a clerical error, the error will be corrected at the discretion of the Plan Administrator. The administrator



may choose to permit the individual to remain enrolled until the end of the period for which a premium has been paid or terminate the coverage of the Covered Person and refund the premium paid, minus any claims paid. If the Plan Administrator chooses to terminate the coverage of such ineligible person, and the amount of premium to be refunded exceeds the amount of claims the plan has paid, the Administrator may peruse action needed to recoup the benefit overpayment from the ineligible person, or their estate.

**G. Amending and terminating the SHBP**

If the SHBP is terminated, the Covered Person's rights are limited to covered medical expenses incurred before the termination date. The Plan Sponsor reserves the right to, at any time, suspend, amend, or terminate the plan in whole or in part.

## **SHBP AMENDMENT AND TERMINATION**

### **A. Amendment**

The Plan Sponsor has charged the Claim Administrator with the responsibility for creating and maintaining all documentation relating to the establishment and operation of the SHBP. As such, the Plan Administrator has the sole right and responsibility to amend this and all SHBP documents. Amendments made implemented at any time, without prior notice, and from time to time as needed, via written instrument signed by an authorized officer of the University. If the adoption of any amendment modifies the material terms of the SHBP, the Plan Administrator will make all reasonable efforts to notify all plan participants as soon as possible.

### **B. Termination of SHBP**

The Plan Sponsor reserves the right to terminate the SHBP at any time without prior notice. If such termination is warranted, it will be up to the Plan Administrator to notify the Covered Person. Such notification will be given as soon as feasibly possible following receipt of written resolution from the University.

### **C. Use and Role of a Trustee**

The Plan Sponsor reserves the right to establish a Trust to meet the financial responsibilities of the plan, pay administrative expense and invest assets in accordance with prudent investment strategies.

### **D. Investment Policy of Plan Assets**

The Trustee or Plan Sponsor may invest and reinvest the principal and income of the Fund and keep the Fund invested, without distinction between principal and income, in stocks, bonds, notes, mortgages, other securities, trust and participation certificates, or in other property, including units of participation in any common trust funds established by the Trustee, or in any savings account, certificate of deposit, or similar instrument whether or not maintained by the Trustee, as the Trustee or Plan Sponsor deems proper, provided that the investments are of a kind authorized by the law for investments by fiduciaries. Notwithstanding the foregoing, the Plan Sponsor may from time to time furnish the Trustee a written statement of investment policy which shall have the effect of limiting the nature of investments the Trustee is authorized to acquire and hold.

**PLAN YEAR 2022 (AUGUST 1, 2022 TO JULY 31, 2023)****A. Eligible Students**

Only Undergraduate students who have paid the Mandatory UHS Health Fee may enroll in the Student Health Benefit Plan (SHBP). Students requesting SHBP Family Plan coverage must also pay the UHS Family Plan Health Fee.

1. All Undergraduate domestic and international students deemed eligible and who are automatically enrolled in SHBP:
  - a. Matriculated in a day academic program taking five (5) or more tuition billed credits in the semester,
  - b. Have not completed the Online SHBP Waiver form before the waiver deadline.
2. Students who are not automatically enrolled but may request to purchase SHBP coverage:
  - a. Undergraduate students who are matriculated in a day academic program taking fewer than five (5) credits per semester.
  - b. Graduate student matriculated in a day academic program who has paid the Continuous Enrollment Fee for the semester.
  - c. Matriculated into an undergraduate program through Continuing Education or University Without Walls, are legal residents of Massachusetts and are taking six or more credits per semester.
  - d. Matriculated into a Graduate program through Continuing Education, are legal residents of Massachusetts, and are taking six (6) or more credits per semester.
  - e. Online students matriculated into a Graduate program through Continuing Education, are legal residents of Massachusetts, and are taking six (6) or more credits per semester.
  - f. Matriculated Continuing Education Students participating in off-campus programs.
3. Students who are not eligible:
  - a. Non-matriculated students are not eligible for SHBP.
4. Requirements for student Family Plan enrollment:
  - a. The student is enrolled in SHBP,
  - b. The student has paid the Student Health Fee,
  - c. The student has paid the Family Student Health Fee,
  - d. Student provides required documentation of family members.

**B. Enrollment / Waiver**

All domestic and International students studying in person, remotely or on-line and residing on campus or anywhere in the United States who show proof of comparable coverage from a US based domestic insurance company with claims being paid within the United States can waive the UMass SHBP. Insurance plans based outside of the US are not considered comparable coverage and will not be accepted. All waivers will be audited and if coverage is confirmed, the insurance fee will be removed from their tuition bill.

International students will be automatically enrolled and may request a waiver at University Health Services. Prior to going to UHS to request the waiver please read the International Students SHBP Waiver requirements on the University Health Services website: <http://www.umass.edu/uhs/insurance> and be prepared to provide appropriate information.

Waivers must be received by the end of the Add/Drop with No Record period which is two weeks after the start of the semester:

- Annual: September 8, 2022
- Spring (new students only): February 1, 2023

Coverage is automatically waived for the Spring Semester if an online or International waiver is approved for the Fall Semester; a second waiver is not required. Only new or transfer students will need to submit an online waiver for the Spring Semester.

Day (not Continuing Education) students enrolled in SHBP for the fall semester will be automatically billed for the spring semester. Fall enrollment of Family Plans and of eligible Continuing Education students are not automatically billed for spring; sign up at UHS before the end of Add / Drop is required if spring coverage is desired.

Students enrolled in the fall who do not need spring coverage may request a spring waiver at University Health Services before the end of the Add/Drop with No Record period.

To submit the online Waiver Form:

1. Go to [www.spire.umass.edu](http://www.spire.umass.edu)
  2. Select the Health Waiver page link;
  3. Click on the Online Waiver Site link; and
  4. Complete and submit the online waiver form
- Or
1. Go to: [www.wellfleetstudent.com](http://www.wellfleetstudent.com)
  2. With the "Find Your School" smart search feature located in the center of the page, start by typing UMass;
  3. Select University of Massachusetts and enter;
  4. From the UMass page, you can waive by clicking "Waive";
  5. Enter your last name, Student ID and Date of Birth, click "Continue";
  6. Complete all information as directed; and "Submit";
  7. Your request will NOT be completed until you:
    - Check the box confirming that your information is correct;
    - Provide your electronic signature; and
    - Click the submission button

A confirmation e-mail is sent within minutes of successfully completing the waiver request. Print and save this e-mail as proof of your waiver. If you do not receive a confirmation e-mail, please call the Claim Administrator for assistance. The entire waiver process takes approximately 15 days. If, after 14 days, you continue to see a charge for SHBP on your bill, please call UHS Patient Services.

To request a Waiver at University Health Services:

- Review the waiver requirements online on the UHS website.
- Go to UHS Patient Services.
- Provide appropriate documentation.