

Domestic Student Health Insurance Plan

2006-2007



WESTERN OREGON UNIVERSITY

Underwritten by:
Combined Insurance Company of America
Chicago, IL
Policy #CUH201098

Acordia Somerton
STUDENT INSURANCE SERVICES

TO PARENTS AND STUDENTS

All Western Oregon University Students, enrolled for 9 or more on-campus credit hours during the Fall, Winter, or Spring terms, are automatically assessed a Student Health Fee each term, which includes a \$20.50 Automatic Limited Health insurance fee, (a \$2,500 benefit plan). Regardless of other insurance coverage, students may not waive either part of this fee.

Students enrolled in 8 or fewer credit hours may choose to pay the Student Health fee and have access to the Student Health and Counseling Center on campus. However, they are not eligible for the Automatic Limited insurance.

The Optional Extended Health insurance, a more comprehensive plan is available to students enrolled in 9 or more credit hours. The Optional Extended Plan provides major medical coverage for the students and their eligible dependents. **The University recommends that you seriously consider adding the Extended Health insurance coverage if the Limited Plan is the only plan covering the student. The Limited Plan provides very basic coverage and by itself is not adequate to cover major illnesses or injuries.**

Promotion of good health for our students has always been our concern. This brochure summarizes how the Student Health Insurance Plan works, what it covers and how the plan may help you with medical costs. After you've read about the Student Health Insurance Plan, keep these important facts in mind:

- All students enrolled in the Limited Plan will receive a Medical ID card 6-8 weeks from the beginning of the term. Please keep your insurance card with you at all times and show it to the doctor or hospital when you seek medical treatment. **As long as you continue to meet eligibility requirements, your card will be valid during the entire policy year (9/25/06 - 9/24/07). You will not receive a new card each term.**
- Learn about your University's Student Health and Counseling Center (SHCC), its location, hours of operation, and the types of services it offers. If possible, go first to SHCC for treatment during their regular hours of operation. They can help you locate medical providers when you need additional care or specialists.
- You may choose any provider you wish.

WHO IS ELIGIBLE TO ENROLL

AUTOMATIC LIMITED HEALTH INSURANCE COVERAGE (For Students Only)

All students at Western Oregon University who **register and pay for 9 or more on-campus credit hours** for Fall, Winter, or Spring terms are automatically enrolled in the Limited Health Insurance Coverage ("Limited Plan"). The cost for this coverage is \$20.50 per term and is included in the Student Health Fee.

Summer coverage is available to students on a voluntary basis. You do not have to be attending school to obtain Summer coverage as long as you were on the Plan during the Spring term. If you wish to purchase the Plan for Summer, you must complete an enrollment form and send it to Acordia Somerton Student insurance with a check for \$20.50, or you may enroll online at www.somerton-ins.com.

The Optional Extended Plan may be purchased for the Summer Session only if the Limited Plan coverage is also purchased.

OPTIONAL EXTENDED HEALTH INSURANCE COVERAGE

(For Students and their Dependents)

All Western Oregon University students who are taking **9 or more credit hours** are also eligible to purchase the Optional Extended Health Insurance Coverage ("Extended Plan"). Eligible students who are enrolled in the Extended Plan may also insure their Dependents. Eligible Dependents are the spouse and unmarried children under 19 years of age (25 years of age if a full-time student at an accredited institution of higher learning and are fully dependent on the insured student).

To be insured under the Optional Extended Health Plan, the student must have paid the required premium and his/her name, student number and date of birth must have been included in the declaration made by the School or the Administrative Agent to the Insurer. All students must actively attend classes for the first 30 consecutive days following their effective date for the term purchased, except in the case of medical withdrawal or during school authorized breaks.

Coverage for eligible Dependents will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student. No Dependent's coverage shall become effective unless the student is insured or simultaneously becomes insured under the plan. An eligible Dependent confined to a Hospital on the day the Dependent would otherwise become a Insured Person will become a Insured Person only upon discharge from the Hospital.

If a child is born to an Insured Student, that child will be covered under the policy for the first 31 days after: 1) birth of a newly born child; 2) the effective date of adoption of the child; or 3) the date the child is placed for adoption. Coverage for such child will be for Sickness or Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Coverage for the adopted child will include the necessary care and treatment of medical conditions existing prior to the date of placement. Benefits will be provided on the same basis as any other Insured Person. The Insured Student will have the right to continue such coverage for the child beyond 31 days. To continue the coverage the Insured must pay the required additional premium for the continued coverage, within 31 days after the birth, adoption or placement for adoption. The Company must receive written notification of the birth or adoption and the appropriate premium must be remitted on or before the 32nd day. If the Insured Student does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth, adoption or placement for adoption.

The Company maintains its right to investigate student (and dependent) status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium less any claims paid.

WHEN COVERAGE BEGINS

Insurance under the Policy will become effective at 12:01 a.m. on the **latest of the** :

- Policy effective date;
- Beginning date of the term for which premium has been paid;
- Day after the Enrollment Form (if applicable) and premium payment are received by the Company, Plan Administrator or University; or
- Day after the date of postmark if the Enrollment Form is mailed.

Coverage for Dependents will become effective at 12:01 a.m. on the **latest of the**:

- Policy effective date;
- Beginning date of the term for which premium has been paid;
- Day after the date the required individual Enrollment Form and premium payment are received by the Company, Plan Administrator or University when premium payment is made within 31 days of the student's enrollment in the University's insurance plan; or
- Day after postmark date when the enrollment form is mailed.

IMPORTANT NOTICE - The cost of insurance will not be pro-rated if the student enrolls in classes past the first date of coverage for which he or she is applying.

WHEN COVERAGE ENDS

Insurance of all Insured Persons terminates at 12:01 a.m. on the earliest of the:

- ♦ Date the policy terminates for all Insured Persons;
- ♦ End of the period of coverage for which premium has been paid;
- ♦ Date the Insured Person ceases to be eligible for the insurance; or
- ♦ Date the Insured Person enters military service.

COVERAGE IS NOT AUTOMATICALLY RENEWED. Eligible Persons must re-enroll when coverage terminates to maintain coverage.

PROGRAM COSTS

	FALL	WINTER	SPRING	SUMMER
	9/25/06- 1/8/07	1/8/07- 4/2/07	4/2/07- 6/25/07	6/25/07- 9/24/07
Automatic Limited Plan*	\$20.50	\$20.50	\$20.50	\$20.50
*included in your Student Health Fee which also includes nurse advice.				
Extended Plan (includes online administration)				
Student	\$ 568	\$ 568	\$ 568	\$ 568*
Spouse	\$1,211	\$1,211	\$1,211	\$1,211
Child	\$ 903	\$ 903	\$ 903	\$ 903
*Student must purchase Summer Limited insurance before buying Summer Extended insurance.				

IMPORTANT NOTICES

PLAN REFUNDS - Premiums received by the Company are fully earned upon receipt. Refund of premium will be considered only:

1. For any student who does not attend school during the first thirty (30) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium portion (\$20.50) of the Student Health Fee will be made. **This includes a student who never showed up, dropped below 9 credits or withdrew from school during this period;** or
2. For a Insured Person entering the Armed Forces of any country. Such person will not be covered under the Policy as of the date of his/her entry into the service. A refund of unused premium will be made for such person within 90 days of withdrawal from school when written notice is received by the Company. Premiums are calculated based on the plan term and will not be pro-rated.

Refunds of premium for the above instances will be considered only upon written request received by Acordia Somerton Student Insurance within 30 consecutive days of the effective date of the term purchased except as otherwise noted. **No other refunds will be allowed.** All refunds may be assessed a \$25.00 processing fee by the Servicing Agent. Please see the policy on file with the School for further refund restrictions.

NON-SUFFICIENT FUNDS - A \$25.00 charge will be assessed by the Plan Administrator on returned checks due to non-sufficient funds.

WHEN DO I USE THE STUDENT HEALTH & COUNSELING CENTER?

Students are advised to consult initially with the Western Oregon University's Student Health and Counseling Center for outpatient care before incurring medical expenses off-campus. Dependents are not eligible to use the Student Health and Counseling Center.

PREFERRED PROVIDER ORGANIZATION

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

The student insurance plan has a feature known as Preferred Provider Organization (PPO) which provides medical care at discounted rates. First Health is the PPO network provider for the 2006-2007 school year. This network of hospitals, doctors, and other care providers has agreed to limit the amount they charge for certain services when the student uses a First Health Provider.

If non-PPO providers are used for medical treatment, the Student Health Plan will pay 60% of the Reasonable and Customary charges, (unless otherwise specified in the Schedule of Medical Benefits), leaving the student with a higher out-of-pocket expense. The Extended Plan will pay 75% of the Preferred Allowance when the PPO network is utilized. Each student will receive an identification card as a participant in the First Health network, and he/she must show that card to the Provider before services are rendered to receive services at discounted rates.

Through First Health Network, we offer a vast network of Medical Facilities within the United States. Over 4,000 medical facilities and over 400,000 doctors are within this network.

To locate a provider in this network visit our website at www.firsthealth.com, first click the "Consumer" link, next click the "Electronic Directory" link, then enter your search criteria. You can also find a provider by calling the First Health Network at (800) 226-5116.

HOW MUCH DOES THE INSURANCE PLAN PAY?

The Company will pay benefits as outlined in this brochure for Covered Expenses incurred by a Insured Person while insured under the Policy for a covered Injury or covered Sickness.

The services listed in the Schedule of Medical Benefits are payable at the rate specified in the Schedule, subject to a Maximum Benefit of \$2,500 for the Limited Plan (per policy year), and an Aggregate Lifetime Maximum Benefit of \$50,000 for the Extended Plan, for each covered Injury or Sickness, except as otherwise specified.

In no event will the Company pay more than the Reasonable and Customary charges for Covered Expenses incurred for treatment, which is rendered during the period for which the appropriate premium has been paid.

See Policy for further details of benefit descriptions. The Policy is on file at the University.

DEFINITIONS

Accident means a specific unforeseen event, which happens while the Insured Person is covered under this Policy and which directly, and from no other cause results in an Injury.

Coinurance means the percentage of Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

Complications of Pregnancy means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:

- ♦ acute nephritis or nephrosis; and
- ♦ cardiac decompensation or missed abortion; and
- ♦ similar medical and surgical conditions of comparable severity; and
- ♦ non-elective caesarean section; and
- ♦ termination of an ectopic pregnancy; and
- ♦ spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Not included are: (a) false labor, occasional spotting or doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and pre-eclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

Co-payment means the specified dollar amount an Insured Person must pay for specified charges. The co-payment is separate from and not a part of the Deductible or Coinurance.

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) for Network Providers, not in excess of the Preferred Allowance; (b) for Non-Network Providers, not in excess of the Reasonable and Customary Expenses; (c) not in excess of the charges that would have been made in the absence of this insurance; and (d) incurred while this Policy is in force as to the Insured Person.

Covered Percentage: means that part of the Covered Charge that is payable by the Company after the Deductible or Co-payment has been met.

Custodial Care: means services and supplies, including room and board charges, which are furnished mainly to help a person meet his or her routine daily needs and can be furnished by someone who has no professional health care training.

Deductible means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

Dependent means: (a) the Insured Student's spouse residing with the Insured Student or Domestic Partner residing with the Insured Student; or (b) the Insured Student's unmarried Children under the age of nineteen years or to age 25, if they are full-time students at an accredited school. Children must be fully supported by the Insured Student. Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. To continue the newborn child's dependent benefits past the first 31 days, the Insured Student must notify Us in writing within 31 days of the child's birth. The term "children" includes an Insured Student's biological children; step-children; adopted children from the date of placement in the Insured Student's home and who depend on the Insured Student for their full support.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of physical handicap or mental retardation; and (b) became so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

Within 31 days after the child reaches the age limit, the Insured Student must send us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification; or (d) a duly licensed and certified nurse practitioner performing services within the lawful scope of nurse practitioner practice.

Claims submitted by a physician assistant practicing under the circumstances set forth in ORS 677.515(4) are covered the same as if submitted by the supervising physician. Benefits for any service covered under the Policy that is within the lawful scope of practice of a duly licensed optometrist shall also be covered if performed by a physician. Benefits shall be paid for any service covered under the Policy performed by a physician that is within the scope of a licensed clinical social worker. Benefits shall also be paid when referred to a clinical social worker to perform the covered service. Surgical services covered under the Policy when performed by a physician that are within the scope of a dentist's license shall also be covered when performed by a dentist.

Domestic Partner means the same sex partner of an Insured Student who has filed a "Declaration of Domestic Partnership" with the Policyholder's administrative offices and who: (a) has been residing with the Insured Student for at least 12 consecutive months, and intends to do so indefinitely; (b) is considered the Insured Student's "sole Domestic Partner"; (c) is, along with the Insured Student, at least 18 years of age; (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and (e) is, along with the Insured Student, not married or related by blood.

Domestic Student is a student classified as a United States Citizen or eligible Non-Citizen (Permanent Resident or Refugee).

Effective Date means the first date a student becomes covered under the Policy.

Elective Treatment means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; treatment of infertility and routine physical examinations.

Experimental or Investigational Care means a service or supply:

- (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or
- (b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

Hospital means a facility which meets all of these tests:

- (a) it provides inpatient services for the care and treatment of injured and sick people; and
- (b) it provides room and board services and nursing services 24 hours a day; and
- (c) it has established facilities for diagnosis and major surgery; and
- (d) it is supervised by a Doctor; and
- (e) it is run as a Hospital under the laws of the jurisdiction in which it is located.

Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility. However, Hospital does include any facility owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program.

Hospital Confinement means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

Injury means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student and his or her covered Dependent(s) while insured under this Policy.

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

Loss means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

Medical Emergency means a medical condition that manifests itself by symptoms of sufficient severity that a prudent lay person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or fetus in the case of a pregnant woman, in serious jeopardy.

Medically Necessary means that a service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice. A service or supply will not be considered as Medically Necessary if:

- (a) it is provided only as a convenience to the Insured Person or provider;
- (b) it is not the appropriate treatment for the Insured Person's diagnosis or symptoms;
- (c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.

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

Network Providers are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

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

Policy Year means the 12 month period beginning on the Policy Effective Date.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Charges.

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature as represented by the 70th-80th percentile of the Medical Data Research (MDR) database.

Sickness means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us and Our mean the Combined Insurance Company of America.

You and Your mean the Insured Person.

HOW DO I USE MY INSURANCE WITH MY TEMPORARY ID CARD?

Medical ID cards may be shipped before or within 6 weeks of your policy effective date. **New ID cards will not be sent if you are renewing coverage during the policy year.**

Providers need your Member ID # from your ID card to identify you, verify your coverage and bill Ameriben/IEC Group. If you need to seek medical treatment prior to receiving your ID card, please use the temporary card attached to the enrollment form and write in your Member #. **Renewing students** will maintain the same Member # each policy year. **New students** can call Acordia Somerton at (800) 853-5899 to obtain their Member # (if purchasing by mail allow 7-14 business days for processing). Without a Member ID you can still seek medical treatment using date of birth and school ID #.

9 GOOD REASONS TO GO TO THE EMERGENCY ROOM

1. Loss of consciousness
2. Intolerable and uncontrollable pain
3. Severe shortness of breath
4. Chest pain
5. Uncontrollable bleeding
6. Poisoning (Note: If possible, call your poison control center first and ask for immediate home-treatment advice)
7. A major injury, such as a head injury.
8. Severe or worsening reaction to an insect bite or sting, or to a medication, especially if breathing is difficult
9. Stupor, drowsiness, or disorientation that cannot be explained.

11 NOT VERY GOOD REASONS TO GO TO THE EMERGENCY ROOM

1. Earache
2. Minor laceration (cut) where bleeding is controlled
3. Minor dog bite where bleeding is controlled
4. Possible broken bone (if bone is showing or if limb is deformed, go directly to Emergency Room)
5. Possible strain
6. A blistered sunburn or minor blistered cooking burns
7. Bee or insect sting or delayed swelling (if there is breathing difficulty, go directly to the Emergency Room)
8. Rash
9. Fever (if there is a convulsion, go directly to the Emergency Room)
10. Sexually transmitted disease (STD)
11. Colds and cough, sore throat, flu

PRIMARY EXCESS PROVISION

After We pay \$250, no benefits in excess of this initial amount are payable under this Policy for any Expense incurred for Injury or Sickness which is paid or payable by: (1) other valid and collectible insurance; or (2) under an automobile insurance policy. (Applicable to Limited Plan Only).

Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured Person for failing to comply with policy provisions or requirements.

SCHEDULE OF MEDICAL BENEFITS

The treatment commencement period is 90 days. **The first \$250 of a claim under the Limited Plan will be paid as primary, everything thereafter will be paid as secondary.** Benefits will be paid under the Limited Plan subject to the Benefit Maximum shown below, (\$2,500). If there is a balance remaining and the Insured student has chosen the Optional Extended Coverage, then the remaining balance will be considered under the Extended Plan benefits, subject to the **\$250 per policy year deductible** and co-insurance amounts as stated below. If a service is excluded from coverage under the Limited Plan, and the Insured student has purchased the Extended Plan, then those excluded Limited Plan Benefits will be considered under the Extended Plan, subject to the deductible and benefit limits as indicated. Dependents are eligible for coverage only under the Extended Plan. All benefits are subject to the Plan Limits and Exclusions as stated within the Policy. Covered expenses must be for treatment by or under the written order of a licensed Doctor and will not exceed an Aggregate Lifetime Maximum of \$50,000 per Covered Injury or Sickness.

The Policy provides benefits for the Reasonable and Customary Charges (R&C) incurred by a Covered Person for loss due to a covered Injury or Sickness. Any Covered Expenses will be paid at **75% of the Preferred Allowance**, except as noted below. If a Preferred Provider is not available in your network area, benefits will be paid at the level of benefits shown as Preferred Provider benefits. If the Covered Expense is incurred due to a life-threatening emergency condition, benefits will be paid at the Preferred Provider level of benefits. In all other situations, when an Out-of-Network provider is used, any Covered Expenses will be paid at **60% of R&C**, except as noted below. The benefits payable are as defined in and subject to all provisions of this Policy and any endorsements thereto.

MAXIMUM BENEFIT PER COVERED INJURY OR SICKNESS	LIMITED PLAN	(OPTIONAL) EXTENDED PLAN	
	<i>\$2,500 per policy year</i>	<i>Aggregate Lifetime: \$50,000 per Injury/Sickness</i>	
INPATIENT BENEFITS (When Hospital Confined)		PREFERRED PROVIDER	OUT-OF-NETWORK
Hospital Semi-Private Room and Board	80% of R&C, up to 5 days	75% of Preferred Allowance	60% of R&C
Hospital Miscellaneous (a) anesthesia, anesthesia supplies and services; (b) operating, delivery and treatment rooms and equipment; (c) diagnostic X-ray and laboratory tests; (d) lab studies; (e) oxygen tent; (f) blood and blood services; (g) prescribed drugs and medicines; (h) medical and surgical, dressings, supplies, casts and splints; (i) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy; (j) chemotherapy treatment with radioactive substances; (k) intravenous injections and solutions, and their administration; (l) physical and occupational therapy; and (m) other necessary and prescribed Hospital expenses.	80% of R&C, up to 5 days	75% of Preferred Allowance \$2,500 per day maximum	60% of R&C \$2,500 per day maximum
Intensive Care/Hospital Expense	80% of R&C, up to 5 days	75% of Preferred Allowance	60% of R&C
Physiotherapy	Paid as Doctor Visit	75% of Preferred Allowance	60% of R&C
Surgeon's Fees When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.	50% of R&C	75% of Preferred Allowance	60% of R&C
Assistant Surgeon	20% of the Paid Surgical Expense	Not Covered	Not Covered
Anesthetist	20% of the Paid Surgical Expense	75% of Preferred Allowance	60% of R&C
Registered Nurses' Services , when prescribed by the attending Doctor during hospitalization	up to \$30 per day	75% of Preferred Allowance	60% of R&C
Doctor Visits , 1 per day - does not apply when related to surgery	\$20 per visit/5 visits per condition	75% of Preferred Allowance	60% of R&C
Inpatient Mental and Nervous Disorders , \$5,000 maximum per Sickness (Extended Plan Only)	Not Covered	75% of Preferred Allowance	60% of R&C
Inpatient Alcohol and Substance Abuse , \$5,000 maximum per Sickness (Extended Plan Only)	\$250 maximum per policy year	75% of Preferred Allowance	60% of R&C

MAXIMUM BENEFIT PER COVERED INJURY OR SICKNESS	LIMITED PLAN <i>\$2,500 per policy year</i>	(OPTIONAL) EXTENDED PLAN <i>Aggregate Lifetime: \$50,000 per Injury/Sickness</i>	
OUTPATIENT BENEFITS (When Not Hospital Confined)		PREFERRED PROVIDER	OUT-OF-NETWORK
Surgeon's Fees (No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.)	50% of R&C	75% of Preferred Allowance	60% of R&C
Day Surgery Miscellaneous , related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and X-ray examinations including professional fees; anesthesia; drugs or medicines, and supplies. R&C are based on the Outpatient Surgical.	80% of R&C	75% of Preferred Allowance \$2,500 maximum	60% of R&C \$2,500 maximum
Anesthetist	20% of the Paid Surgical Expense	Included in Day Surgery	Included in Day Surgery
Assistant Surgeon	Not Covered	Not Covered	Not Covered
Doctor Visits (do not apply when related to surgery)	up to \$20 per visit/5 visits max per condition	75% of Preferred Allowance	60% of R&C
Chiropractic Care	Paid as Doctor Visit	75% of Preferred Allowance up to \$300 per year	60% of R&C up to \$300 per year
Physiotherapy (limited to 10 visits maximum, Extended Plan only)	Paid as Doctor Visit	75% of Preferred Allowance	60% of R&C
Diagnostic X-ray (imaging) and Laboratory Services, including allergy testing and cancer screening (including cervical cancer screening and pap smear)	up to \$150 max per injury/sickness per policy year	75% of Preferred Allowance	60% of R&C
Medical Emergency	80% of R&C	75% of Preferred Allowance \$150 deductible if not admitted, \$1,000 maximum if not admitted.	60% of R&C \$150 deductible if not admitted, \$1,000 maximum if not admitted.
Mental and Nervous Disorders	up to \$250 per policy year for Psychological Evaluation	50% of Preferred Allowance/ up to \$500 per sickness	50% of R&C/up to \$500 per sickness
Alcohol and Substance Abuse	up to \$250 max per Sickness	up to \$40 per visit, maximum of 25 visits per Sickness	
Radiation Therapy and Chemotherapy	up to \$300 per condition	75% of Preferred Allowance	60% of R&C
Injections - allergy	Paid as Doctor Visit	75% of Preferred Allowance	60% of R&C
Prescription Drugs	Not Covered	75% of R&C \$1,200 maximum	60% of R&C \$1,200 maximum
OTHER MEDICAL BENEFITS			
High Cost Procedure Expense	up to \$150 maximum per condition	75% of Preferred Allowance	60% of R&C
Mammography Examination Expense	up to \$150 maximum per condition	75% of Preferred Allowance	60% of R&C
Pelvic and Pap Smear Examination	up to \$150 maximum per condition	75% of Preferred Allowance	60% of R&C
Motor Vehicle Accidents , up to \$5,000 maximum	Not Covered	75% of Preferred Allowance	60% of R&C
Ambulance Services	up to \$100 per condition	60% of R&C	60% of R&C
Consultation Services	up to \$25 max per condition	75% of Preferred Allowance	60% of R&C
Durable Medical Equipment , for Injury only	up to \$150	75% of Preferred Allowance	60% of R&C
External Prosthetic Appliances	Not Covered	75% of Preferred Allowance	60% of R&C
Complications of Pregnancy	Same as any other Sickness	75% of Preferred Allowance	60% of R&C
Maternity	Same as any other Sickness	75% of Preferred Allowance	60% of R&C
MRI/CAT Scan	Not Covered	\$1,000 per policy year	\$1,000 per policy year
Routine Newborn Care	Not Covered	75% of Preferred Allowance	60% of R&C
Dental Treatment , as a result of covered accident to sound natural teeth	up to \$150	60% of R&C	60% of R&C

See Policy for further details of benefit descriptions. Policy is on file at the University.

EXCLUSIONS AND LIMITATIONS

We will not pay benefits for any loss or expense caused by, contributed to, or resulting from:

1. Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Preventative medicines, serums, immunizations, or vaccines, except as specifically provided;
3. Pre-existing Conditions as defined in this Policy.
4. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
5. Illness, Accident, treatment or medical condition arising out of the play or practice of or traveling in conjunction with intercollegiate sports, intercollegiate club sports, and professional sports only in the case where coverage is not provided for such sports activities under the Policy because the Policyholder has a separate policy that covers such sports activities. However, coverage will not be excluded for injuries which occur during covered athletic activities if the Insured Person has a medical release to participate in such activities;
6. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
7. Illness, Accident, treatment or medical condition arising out of hang-gliding, skydiving, glider flying, parasailing, sail planing, racing or speed contests, skin diving, parachuting or bungi-cord jumping;
8. Correction of congenital defects except as specifically provided;
9. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
10. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
11. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of, or attempt to commit a felony, or a crime which would be considered a felony if prosecuted;
12. Injury due to participation in a riot;
13. Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;
14. For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters;
15. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury;
16. Routine periodical physical examinations, except as specifically provided;
17. Expenses for any service or supply not specified in this Policy as a covered service;
18. An amount of a charge in excess of the Reasonable and Customary Expense;
19. Elective Treatment or elective surgery, except as specifically provided;
20. Services not Medically Necessary;

21. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
22. Suicide, attempted suicide, or intentionally self-inflicted injury, whether sane or insane;
23. Injuries incurred by the Insured Person while intoxicated or under the influence of any drug unless taken as prescribed by a Doctor;
24. Voluntary or elective abortion, except as specifically provided;
25. Medicines not taken in the dosage or the purpose prescribed by the Insured Person's Doctor;
26. Testing, treatment, or services for any condition in the absence of Sickness or Injury except as specifically provided;
27. Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury;

ROUTINE NEWBORN CARE

If expenses are incurred for routine newborn care during the 31 days immediately following the birth by a Covered Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Medical Benefits. Such expenses include, but are not limited to, the following: 1) Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother's care; 2) Inpatient Doctor visits for routine examinations and evaluations; 3) Charges made by Doctor in connection with a circumcision; 4) Routine laboratory tests; 5) Postpartum home visits prescribed for a newborn; and 6) Follow-up office visits for the newborn subsequent to discharge from a Hospital.

ADDITIONAL BENEFITS

Benefits are provided as mandated by the State of Oregon Department of Insurance for Mammography, Pelvic Examinations and Cytological Examinations, and Non-prescriptive Elemental Enteral Formula for Home Use.

A detail of these benefits may be found in the Master Policy on file at the University.

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition is a Sickness, Injury, or related condition for which a licensed Doctor was consulted; or for which treatment or medication was prescribed within six (6) months prior to the Effective Date of the Insured Person's coverage under this Policy.

The Pre-existing Condition Waiting Period is six (6) months. If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a six (6) consecutive month period has passed from the Insured Student's effective date, and (b) We will pay only for Loss or expense incurred after such six (6) consecutive month period.

Insured Persons with documentation of prior Creditable Coverage will receive credit towards the Pre-Existing Waiting Period.

Payment will be in accord with the provisions of this Policy. If the Insured Person has a lapse in coverage of more than one term or semester, the Pre-existing Condition Waiting Period will have to be satisfied again.

CREDITABLE COVERAGE

Creditable Coverage includes any of, or a combination of, the following:

- (a) a group health plan, including a Student Health plan;
- (b) a health insurance plan or health maintenance organization (HMO) plan;
- (c) an individual health insurance policy;
- (d) COBRA continuation of coverage;
- (e) a health benefit plan under Chapter 55, Title 10, United States Code pertaining to members of the uniformed services of the United States;
- (f) Medicare or Medicaid;
- (g) a medical care program of the Indian Health Service or of a tribal organization;
- (h) a state health benefits risk pool;
- (i) a health plan offered under FEHBP (Chapter 89 of Title 5, United States Code);
- (j) a health plan under Section 5(e) of the Peace Corps Act; or
- (k) a public health plan.

24-HOUR NURSE ADVICE LINE

Wouldn't you feel better knowing you could get health care answers from a Registered Nurse 24 hours a day? Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24 hours a day, 7 days a week.

HERE'S HOW EASY IT IS:

- ♦ The insured student or insured family member calls the 24-hour nurse advice line.
- ♦ A registered nurse asks a series of questions related to the condition and assesses the caller's condition.
- ♦ The nurse provides information regarding care options to help the caller develop a proactive plan which could include: proceed to an urgent care or emergency facility, follow-up with your primary care provider or school clinic, or develop a home care plan.
- ♦ The nurse can provide information about your PPO network providers in the geographic area closest to your school.

One phone call is all it takes to access a wealth of useful health care information at (866) 241-3793.

NOTE: This program is not insured by Combined Insurance Company of America.

RIGHT OF RECOVERY

We may recover any benefits paid under this Policy to the extent a Covered Person is paid for the same Injury or Sickness by a third party, another insurer, or the Covered Person's uninsured motorists insurance. We may only be reimbursed for the amount of the Covered Person's recovery. Further, We have the right to offset future benefits payable to the Covered Person under this Policy against such recovery.

CERTIFICATE OF CREDITABLE COVERAGE

Your coverage under this Insurance Plan is creditable coverage under Federal Law. When your coverage terminates, you can request a Certificate of Creditable Coverage, which is evidence of your coverage under this health insurance plan. You need such certificate if you become covered under a group health plan or other health plan within 62 days after your coverage under this health insurance plan terminates. If the subsequent health plan excludes or limits coverage for medical conditions you have before you enroll, this certificate may be used to reduce or eliminate those exclusions or limitations. A Certificate of Creditable Coverage may be requested in writing from Acordia Somerton Student Insurance Services.

HOW DO I FILE A CLAIM?

1. After seeking treatment on or off campus, mail the following items to the Claims Administrator (ABS) at the address below:
 - ♦ All itemized medical and hospital bills.
 - ♦ All itemized pharmaceutical receipts (not cash register receipts) showing prescription number, name of drug, date prescribed, and name of person for whom drug is processed.
2. You must mail all medical and hospital bills within 90 days after date of treatment, to the address below. Please include the patient's name and insured student's name, address, School ID Number (if any), Acordia Somerton medical ID number (from your permanent ID card), and name of the university under which the student is insured with the bills. You are not required to include a claim form with your bill, but they are available on request.

AmeriBen/IEC Group
P.O. Box 7186, Boise, Idaho 83707
For claims inquiries call: (800) 953-1801
<https://services.ameriben.com>

Group # 0904015

Access detailed information about your claims status on the web

First access our web site above and then click on "Subscribers." First time users need to register with our Online Services system. To do that, click on the red bar that states "First Time Users Click Here." To authenticate, simply fill out the First Time Users form with your Acordia Somerton medical ID number (from your permanent ID card), date of birth, and your return E-mail address. Your initial password will be sent to you via E-mail.

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment or fine. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

HIPPA PRIVACY NOTICE

Under HIPPA's Privacy Rule we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment materials. If, at anytime, you wish to request a copy of the Combined Insurance Company of America's Privacy Notice, write to 5050 Broadway, Chicago, IL 60640 Attention: HIPPA Office or call 1 (800) 225-4500, select HIPPA.

ACORDIA SOMERTON STUDENT INSURANCE PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a detailed copy of our privacy policy through your school, or by calling us toll-free at (800) 853-5899 or by visiting us at www.somerton-ins.com.

CLAIMS ADMINISTERED BY:

Claims, Eligibility and Coverage Questions

AmeriBen/IEC Group

P.O. Box 7186, Boise, ID 83707

(800) 953-1801

<https://services.ameriben.com>

Group # 0904015

24-HOUR NURSE ADVICE LINE:

(866) 241-3793

PREFERRED PROVIDER:

To Find a Doctor or Provider

First Health

(800) 226-5116

www.firsthealth.com

THE PLAN ADMINISTERED BY:

Acordia Somerton

Student Insurance Services

OR License No. 802263

11017 Cobblerock Drive, Suite 100

Rancho Cordova, CA 95670

(800) 853-5899 or (916) 231-3399

Fax: (916) 231-3398

www.somerton-ins.com

THE UNDERWRITING COMPANY:

Combined Insurance Company of America

Policy # CUH201098

IMPORTANT NOTICE

This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in the state in which the policy was delivered. Complete details may be found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

