



# Student Health Insurance Plan

Plan Year  
17/18

*Designed Exclusively for the International Students of:*

**UW International  
-Green Bay, WI**

2017 - 2018

***Underwritten by:***

National Guardian Life Insurance Company  
Madison, WI

Policy Number: 2017I5B54

Group Number: ST0926SH

Effective: 8/5/2017 - 8/5/2018



***Administered by:***

Consolidated Health Plans  
2077 Roosevelt Ave | Springfield, MA



## Where to Find Help

I need to:	Contact or Visit:
Enroll in the plan as J-1 Scholar and dependents	Student Assurance Services, Inc. (800) 328-2739
Enroll my F-1 dependent in the insurance plan	Consolidated Health Plans 2077 Roosevelt Avenue Springfield, MA 01104 <a href="http://www.studentinsurancechpstudent.com">www.studentinsurancechpstudent.com</a>
Learn about: <ul style="list-style-type: none"> <li>• Insurance Benefits</li> <li>• Preferred Provider Listings</li> <li>• Claims Processing</li> </ul>	Consolidated Health Plans 2077 Roosevelt Avenue Springfield, MA 01104 (877) 657-5030 <a href="http://www.studentinsurancechpstudent.com">www.studentinsurancechpstudent.com</a>
Find a Provider:	Cigna PPO <a href="http://www.cigna.com">www.cigna.com</a>
Find a Prescription Drug Provider:	Cigna Pharmacy Network <a href="http://www.cigna.com">www.cigna.com</a>

## Effective Dates & Costs

The Policy is renewed as a new policy for the term August 5, 2017 to August 5, 2108 as Policy Number 201715B54. All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

Cost and Period of Coverage				
	Annual* 8/5/17 - 8/5/18	Fall* 8/5/17 - 1/15/18	Spring/Summer* 1/15/18 - 8/5/18	Summer* 5/13/18 - 8/5/18
Student	\$1,486	\$664	\$822	\$342
<i>Dependent rates are in addition to the student rate.</i>				
Spouse	\$1,486	\$664	\$822	\$342
Each Child	\$1,486	\$664	\$822	\$342
3 or more Children	\$4,458	\$1,992	\$2,466	\$1,026

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

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, Student Assurance Services, Inc. P.O. Box 196 Stillwater, MN 55082 (800)-328-2739 www.sas-mn.com, or Consolidated Health Plans at 877-657-5030 or on the web at www.studentinsurance.com. If You need assistance resolving a complaint, please contact Us at: 1-800-756-3702.

### COVERAGE

1. Accident and Sickness coverage begins on August 5, 2017, or the date of enrollment in the plan, whichever is later and ends August 5, 2018.
2. Benefits are payable during the Policy Term, subject to any Extension of Benefits.  
Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.
3. The Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. The Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

### CERTIFICATE OF STUDENT HEALTH INSURANCE POLICY

issued by

**NATIONAL GUARDIAN LIFE INSURANCE COMPANY,**

**PO BOX 1191, Madison, WI 53701-1191**

**(Herein referred to as 'We', 'Us' or 'Our')**

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2016) WI ("the Policy").

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### Section 1 — Definitions

The terms listed below, if used in this Certificate, have the meanings stated.

**Accident** means a sudden, unforeseeable external event that causes Injury to an Insured Person.

**Ambulance Service** means transportation to a Hospital by an Ambulance Service.

**Ambulatory Surgical Center**, or mobile surgical facility, means a facility whose primary purpose is to provide elective surgical care, in which the Insured Person is admitted to and discharged from such facility within the same working day and is not permitted to stay overnight, and which is not part of a Hospital. A facility existing for the primary purpose of performing terminations of pregnancy, an office maintained by a Physician for the practice of medicine, or an office maintained for the practice of dentistry will not be considered an Ambulatory Surgical Center under the Policy. A structure or vehicle in which a Physician maintains an office and practices surgery, which can appear to the public to be a mobile office because the structure or vehicle operates at more than one address, will be considered an Ambulatory Surgical Center or mobile surgical facility.

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

**Brand Name Drugs** means drugs for which the drug manufacturer's trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

**Breast Reconstructive Surgery** means surgery to reestablish symmetry between the two breasts.

**Child Health Supervision Services** means Physician-delivered or Physician-supervised services that include periodic visits, including a history, physical examination, developmental assessment and anticipatory guide, and appropriate immunizations and lab tests as consistent with the Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics.

**Coinsurance** means the ratio by which We and the Insured Person share in the payment of Usual and Reasonable expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.

**Complications of Pregnancy** means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these. Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.) Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

**Copayment** means the amount of Usual and Reasonable expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.

**Country of Assignment** means the country in which an Eligible International Student, scholar or visiting faculty member is: 1) Temporarily residing; and 2) Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

**Covered Injury** means a bodily injury that is: 1) Sustained by an Insured Person while he/she is insured under the policy or the School's prior policies; and 2) Caused by an accident directly and independently of all other causes.

**Covered Medical Expense** means those charges for any treatment, service or supplies that are: 1) Not in excess of the Usual and Reasonable charges therefore; 2) Not in excess of the charges that would have been made in the absence of this insurance.

**Covered Sickness** means Sickness, disease or trauma related disorder due to Injury which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Abuse Disorders.

**Deductible** means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Policy. The amount of the Deductible and the frequency (annual or per occurrence) will be shown in the Schedule of Benefits.

**Dependent** means: 1) Your lawful spouse or lawful Domestic Partner; 2) Your dependent biological or adopted child, stepchild, or grandchild under age 26; and 3) Your unmarried biological or adopted child or stepchild who has reached age 26 and who is: (a) primarily dependent upon You for support and maintenance; and (b) incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap. Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

**Elective Surgery or Elective Treatment** means surgery or medical treatment that is: 1) not necessitated by a pathological or traumatic change in the function or structure of any part of the body; and 2) which occurs after the Insured Person's effective date of coverage.

**Elective Treatment** includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include cosmetic surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

**Eligible Student** means a student who meets all enrollment requirements of the School named as the Policyholder in the Insurance Information Schedule.

**Emergency Medical Condition** means a medical condition which: 1) manifests itself by acute symptoms of sufficient severity (including severe pain); and 2) causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention might result in: (a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) Serious impairment to bodily functions; or (c) Serious dysfunction of any bodily organ or part.

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

**Enrollment Date** means the date of enrollment of the individual in the Policy or, if earlier, the first day of the waiting period of such enrollment.

**Essential Health Benefits** mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories

and the items and services covered within the categories:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

**Formulary** means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

**Generic Drugs** means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

**Habilitation/Habilitative Services** means health care services that help the Insured Person keep, learn, or improve skills and functions for daily living. Habilitative Services may include such services as physical therapy, occupational therapy, and speech therapy.

**Home Country** means Your country of citizenship. If You have dual citizenship, Your Home Country is the country of the passport You used to enter the United States. Your Home Country is considered the Home Country for any dependent of Yours while insured under the policy.

**Hospice Care** means a coordinated program of home and inpatient care provided directly or under the direction of a properly licensed Hospice. Such services will include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medical directed interdisciplinary team.

**Hospital** means an institution that: 1) Operates as a Hospital pursuant to law; 2) Operates primarily for the reception, care and treatment of sick or injured persons as inpatients; 3) Provides 24-hour nursing service by Registered Nurses on duty or call; 4) Has a staff of one or more Physicians available at all times; and 5) Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

Hospital does not include the following: 1) Convalescent homes or convalescent, rest or nursing facilities; 2) Facilities primarily affording custodial, educational, or rehabilitant care (unless such rehabilitation is specifically for treatment of physical disability; or 3) Facilities for the aged.

**Hospital Confined or Hospital Confinement** means a stay of eighteen (18) or more consecutive hours as a resident bed patient in a Hospital.

**Immediate Family Member** means the Insured Person and his or her spouse or the parent, child, brother or sister of the Insured Person or his or her spouse.

**Insured Person** means You or Your dependent while insured under the policy.

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

**International Student** means an international student: 1) With a current passport and a student Visa; 2) Who is temporarily residing outside of his or her Home Country; and 3) Is actively engaged, on a full-time basis, as a student or in educational research activities through the Policyholder. In so far as the policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

**Leave of Absence** means a planned interruption in a registered Student's education and may be granted up to one semester.

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

**Mastectomy** means the removal of all or part of the breast for Medically Necessary reasons as determined by a licensed Physician.

**Medically Necessary** means medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. The Insured Person's health care provider determines if the medical treatment provided is medically necessary.

**Mental Health Disorder** means a condition that substantially limits the life activities of the 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.

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

**Non-Network Providers** are providers who have not agreed to any pre-arranged fee schedules.

**Out-of-pocket Expense Limit** means the amount of Usual and Reasonable expenses that an Insured Person is responsible for paying.

**Palliative care** means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he or she experiences the stress of the dying process, rather than at treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

**Physician** means a: 1) Doctor of Medicine (M.D.); or 2) Doctor of Osteopathy (D.O.); or 3) Doctor of Dentistry (D.M.D. or D.D.S.); or 4) Doctor of Chiropractic (D.C.); or 5) Doctor of Optometry (O.D.); or 6) Doctor of Podiatry (D.P.M.); who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered. A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

**Physician** will also mean any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician. The term Physician does not mean any person who is an Immediate Family Member.

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

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

**School or College** means the college or university attended by You.

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

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

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

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

**Student Health Center or Student Infirmary** means an on-campus facility that provides: 1) Medical care and treatment to Sick or Injury students; and 2) Nursing services.

A Student Health Center or Student Infirmary does not include: 1) Medical, diagnostic and treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or 2) Inpatient care.

**Substance Use Disorder** means any condition or disorder that substantially limits the activities of the Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual or Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Total Disability or Totally Disabled**, as it applies to the Extension of Benefits provision, means: 1) With respect to an Insured Person, who otherwise would be employed: (a) His or her complete inability to perform all the substantial and material duties of his or her regular occupation; with (b) care and treatment by a Physician for the Covered Injury or Covered Sickness caused the inability; 2) With respect to an Insured Person who is not otherwise employed: (a) His or her inability to engage in the normal activities of a person of like age and sex; with (b) Care and treatment by a Physician for the Covered Injury or Covered Sickness causing the inability; or (c) His or her Hospital confinement or home confinement at the direction of his or her Physician due to a Covered Injury or a Covered Sickness, except for visits to receive medical treatment.

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

**Usual and Reasonable (U & R)** means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a: 1) Like service by a provider with similar training or experience; or 2) Supply that is identical or substantially equivalent.

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

**We, Us, or Our** means National Guardian Life Insurance Company or its authorized agent.

**You, Your** means a student of the Policyholder who is eligible and insured for coverage under the policy.

## **Section 2 – Eligibility, Enrollment and Termination**

All registered international students, scholars and ESL students holding student visas are eligible to enroll in this insurance plan. Students are required to purchase this insurance plan unless they are under one of the following organizations which has a waiver agreement in place with the SHIP office; German Academic Exchange Service (DAAD), Master of Engineering On-line Program, KAUST Gifted Student Program, Royal Thai Embassy (OEA), Saudi Arabia Cultural Mission (SACM), Norwegian National Insurance Scheme (HELCO), University of Southampton (stays of less than 12 months), Malaysian Government (Public Service Department/JPA only, or Student Scholarship Program (SSP) of SABIC. The UW System institutions require health insurance for anyone on an F-1 visa, J-1 or J-2 visa status, except those on OPT. Students on OPT status are eligible for the insurance plan.

The UW System institutions offer health insurance to F-1 students on OPT participating in institution-sponsored programs while on student visas.

Students must attend classes within the first 31 days beginning with the first day for which coverage is effective. Any student withdrawing from the College during the first 31 days after the effective date of coverage will not be covered under the insurance plan. A full refund of premium will be made. We will refund a pro-rata portion of the premium actually paid for any individual who withdraws from school during his/her first semester and returns to his/her home country. A written request must be provided within 60 days of such departure.

Covered participants may also purchase dependent coverage for their eligible dependents. Eligible dependents are as defined in the certificate. Dependent eligibility runs concurrently with the Student eligibility. At no point will a Dependent's coverage begin before or continue after a Student's enrollment (except as provided in the extension of benefit provision).

F-1, J-1 and J-2 visa holders presenting evidence of comparable ACA-compliant coverage satisfactory to the University may apply for a waiver of the institution-required health insurance plan. Approved waiver plans are: German Academic Exchange Service (DAAD), Master off Engineering On-line Program, KAUST Gifted Student Program, Royal Thai Embassy (OEA), Saudi Arabia Cultural Mission (SACM), Norwegian National Insurance Scheme (HELCO), University of Southampton (stays of less than 12 months), Malaysian Government (Public Service Department/JPA only, or Student Scholarship Program (SSP) of SABIC. The following students are not eligible to enroll in the insurance plan: students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses; students taking distance learning, home study, correspondence, television courses, or courses taken for audit do not fulfill the eligibility requirements that the student actively attend classes. The online restriction does not apply to students who are completing their degree requirements while engaged in practical training.

The Plan Administrator reserves the right to determine if the student has met the eligibility requirements. If the Plan Administrator later determines the eligibility requirements have not been, its only obligation is to refund the premium.

**Termination Dates:** An Insured Person's insurance will terminate on the earliest of: 1) The date the Policy terminates for all insured persons; or 2) The end of the period of coverage for which premium has been paid; or 3) The date an Insured Person ceases to be eligible for the insurance; or 4) The date an Insured Person enters military service; or 5) For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks); 6) For International Students, the date the student ceases to meet Visa requirements; 7) On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error.

**Extension of Benefits:** Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended if an Insured Person is Hospital confined or Totally Disabled due to a Covered Injury or Covered Sickness. The coverage for the condition causing the Hospital confinement or Total Disability will be extended for up to a minimum of twelve (12) months from the Termination Date.

*See attached Endorsement revising this provision.*

## **Section 3— BENEFITS**

Benefits are payable under the policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Insured Person. **The Covered Medical Expenses for an issued Policy will be only those listed in the Schedule of Benefits with all applicable Deductibles, Coinsurance and Copayment amounts, and maximums for each benefit shown in the Schedule of Benefits.** No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits. Subject to payment of any required Deductible, when you



suffer a Loss from Covered Accident or Covered Sickness, we will pay benefits as follows:

**Preventive Services:** The following services shall be covered without regard to any Deductible, or Coinsurance requirement that would otherwise apply: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; 2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved; 3) With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 4) With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph 1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

**Essential Health Benefits**

Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, treatment or services are added to the list of Essential Health Benefits by a governing authority, the policy benefits will be amended to comply with such changes.

**Treatment of Covered Injury or Covered Sickness:** We will pay benefits for the Usual and Reasonable Charges for Covered Medical Expenses that are incurred by the Insured Person due to a Covered Injury or Covered Sickness. Benefits payable are subject to: 1) Any specified benefit maximum amounts; 2) Any Deductible amounts; 3) Any Coinsurance amount; 4) Any Copayments; 5) The Maximum Out-of-Pocket Expense Limit.; 6) the Exclusions and Limitations provision; 7) Use of a Network Provider, if any.

**Benefit Period:** The first treatment of a Covered Injury or Covered Sickness must begin within the time stated in the Benefit Period shown in the Schedule of Benefits. A Benefit Period begins when the Insured Person experiences a Loss due to Covered Injury or Covered Sickness. The Benefit Period terminates at the end of the period defined in the Schedule of Benefits. Any extension of a Benefit Period, if provided elsewhere in the Policy, is limited to medical treatment of the Covered Injury or Covered Sickness that is ongoing on the termination date of the Insured Person's coverage. The Insured Person's termination date of coverage as it would apply to any other Covered Injury or Covered Sickness will not be affected by such extension.

**Out-of-Pocket Expense Limit:** The Out-of-Pocket Expense Limit is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person's Coinsurance amounts, Deductibles, and Copayments will apply toward the Out-of-Pocket Expense Limit.

**Basic Injury and Sickness Benefit**

- If:
1. an Insured Person incurs expenses as the result of Covered Injury or Covered Sickness, then
  2. We will pay the benefits stated in the Schedule of Benefits for the services, treatments and supplies described in the Covered Medical Expenses provision below.

Payment will be made, Subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits:

1. For the Usual and Reasonable Charges for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

**Covered Medical Expenses**

We will pay the Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness. **The Covered Medical Expenses for an issued Policy will be only those listed below and as shown in the Schedule of Benefits.**

**See NPPO(2016) WI at the end of this certificate.**

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

Principal Sum for Double Dismemberment or Loss of Life. .... \$5,000  
½ Principal Sum for Single Dismemberment... .. \$2,500

Loss must occur with 180 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one loss occurs as the result of any one Accident. This benefit is payable in addition to any other benefits payable under the Policy.

**Inpatient Benefits**

**Hospital Room and Board Expense**, including general nursing care. Benefits may not exceed the lesser of the daily semi-private room or the amount listed.

**Intensive Care Unit**, including 24-hour nursing care. **This benefit is NOT payable in addition to room and board charges**



**incurred on the same date.**

**Hospital Miscellaneous Expenses** while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: 1. the cost for use of an operating room; 2. Prescribed medicines; 3. Laboratory tests; 4. Therapeutic services; 5. X-ray examinations; 6. Casts and temporary surgical appliances; 7. Oxygen, oxygen tent; 8. Blood and blood plasma; and 9. Miscellaneous supplies.

**Preadmission Testing** for routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital. These tests must be performed within three working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

**Physician's Visits while Confined** not to exceed one visit per day. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

**Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician's visits.

**Human Organ Transplant Benefit** for Medically Necessary human organ or tissue transplant, as specified in the Schedule of Benefits.

**Congenital Heart Disease Surgery** for Medically Necessary treatment of congenital heart disease, as specific in the Schedule of Benefits.

**Registered Nurse's Services** when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.

**Physical Therapy while Confined** when prescribed by the attending Physician or physiotherapist.

**Rehabilitative and Habilitative Therapy** when prescribed by the attending Physician, limited to 60 days per year.

#### **Outpatient Benefits**

**Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** for outpatient surgery (including fees for pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the outpatient surgery benefit or the inpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value.

**Outpatient Surgery Miscellaneous** (excluding non-scheduled surgery) surgery performed in a hospital emergency room, trauma center, physician's office, outpatient surgical center or clinic. Benefits will be paid for services and supplies, including: Operating room; Therapeutic services; Oxygen, oxygen tent; Blood and blood plasma; and Miscellaneous supplies.

**Rehabilitative and Habilitative Therapy** when prescribed by the attending Physician. Limited to one visit per day.

**Emergency Services Expenses** only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

**In Office Physician's Visits** for Physician's office visits. We will not pay for more than one visit per day. Physician's Visit benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

**Urgent Care Centers or Facilities** for services provided at an Urgent Care Center or Facility, as shown in the Schedule of Benefits. We will not pay for more than one visit per day.

**Diagnostic X-ray Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a physician.

**Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

**Prescription Drugs** for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made.

- a. Off-Label Drug Treatments when prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
  1. The drug is approved by the FDA;
  2. The drug is prescribed for the treatment of a life-threatening condition, including cancer, HIV, or AIDS;
  3. The drug has been recognized for treatment of that condition by one of the following: The American Medical

Association Drug Evaluations; The American Hospital Formulary Service Drug Information; The United States Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal. When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items 1., 2., and 3. of this benefit

- b. Specialty Drugs are Prescription Drugs which:
1. Are only approved to treat limited patient populations, indications, or conditions; or
  2. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
  3. Have limited availability, special dispensing and delivery requirements, and/or additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

**Outpatient Miscellaneous Expenses (Excluding surgery)** for miscellaneous outpatient expenses (excluding surgery) incurred for the treatment and care of a Covered Injury or Covered Sickness. Expenses must be incurred on the advice of a Physician. Miscellaneous outpatient expenses include other reasonable expenses for services and supplies that have been prescribed by the attending Physician.

**Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

As used in this benefit:

**Hospice Care** means a coordinated program of home and inpatient care provided directly or under the direction of a properly licensed Hospice. Such services will include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medical directed interdisciplinary team.

**Palliative care** means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he or she experiences the stress of the dying process, rather than at treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

#### **Other Benefits**

**Ambulance Service** for transportation to or from a Hospital by ambulance.

**Braces and Appliances including Prosthesis and Orthotics** when prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We will also not pay for braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

**Durable Medical Equipment** for the rental or purchase of durable medical equipment, including, but not limited to, Hospital beds, wheel chairs, and walkers. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable medical equipment must:

- a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
- b. Be able to withstand repeated use; and
- c. Generally not be useful to a person in the absence of Injury or Sickness.

**Maternity Benefit** for maternity charges as follows:

- a. Routine prenatal care
- b. Hospital stays for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness.  
Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.
- c. Inpatient Physician charges or surgeon charges will be covered the same as for any other Covered Sickness for both mother and newborn child.
- d. Physician-directed Follow-up Care including:
  - 1) Physician assessment of the mother and newborn;
  - 2) Parent education;
  - 3) Assistance and training in breast or bottle feeding;

- 4) Assessment of the home support system;
- 5) Performance of any prescribed clinical tests; and
- 6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "2", the home health care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn.

e. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness.

**Routine Newborn Care** when expenses are incurred for routine newborn care during the first 60 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:

- a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
- b. Inpatient Physician visits for routine examinations and evaluations;
- c. Charges made by a Physician in connection with a circumcision;
- d. Routine laboratory tests;
- e. Postpartum home visits prescribed for a newborn; and
- f. Follow-up office visits for the newborn subsequent to discharge from a Hospital.
- g. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the treatment of such newly born child. The benefit payable for transportation will not exceed the Usual and reasonable charges.

**Consultant Physician Services** when requested and approved by the attending Physician.

**Accidental Injury Dental Treatment** as the result of Injury. Routine dental care and treatment are not payable under this benefit.

**Student Health Center/Infirmary Expense Benefit** if an Insured Student incurs expenses as the result of treatment at a Student Health Center/Infirmary, we will pay the expenses incurred. Benefits will not to exceed the amount shown in the Schedule of Benefits.

**Sports Accident Expense Benefit** for an Insured Student as the result of covered sports accident while at play or practice of intercollegiate, intramural or club sports as shown in the Schedule of Benefits.

**Pediatric Dental Care Benefit** for the following dental care services for Insured Persons up to age 19.

- a. Emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
- b. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
  - 1) Prophylaxis (scaling and polishing teeth at six (6) month intervals;
  - 2) Topical fluoride application at six (6) month intervals where the local waters supply is not fluoridated;
  - 3) Sealants on unrestored permanent molar teeth; and
  - 4) Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
- c. Routine Dental Care: We cover routine dental care provided in the office of a dentist including:
  - 1) Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
  - 2) X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
  - 3) Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
  - 4) In-office conscious sedation;
  - 5) Amalgam, composite restorations and stainless steel crowns; and
  - 6) Other restorative materials appropriate for children.
- d. Endodontic services, including procedures for treatment of diseased pulp canals, where Hospitalization is not required.
- e. Prosthodontic services as follows:
  - 1) Removable complete or partial dentures, including six (6) months follow-up care; and
  - 2) Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate. Fixed bridges are not covered unless they are required:
    - a. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full

- complement of natural, functional and/or restored teeth;
  - b. For cleft palate stabilization; or
  - c. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.
  - f. Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.
- Procedures include but are not limited to:
- a. Rapid Palatal Expansion (RPE);
  - b. Placement of component parts (e.g. brackets, bands);
  - c. Interceptive orthodontic treatment (during which orthodontic are placed for active treatment and periodically adjusted);
  - d. Removable appliance therapy; and
  - e. Orthodontic retention (removal of appliances, construction and placement of retainers).

**Pediatric Vision Care Benefit** for Insured Persons who are age 18 and under. We will provide benefits for:

- a. One vision examination per Policy Year; and
- b. One pair of prescription and eyeglass frames every two Policy Years.

**Chiropractic Care Benefit** – for treatment of a Covered Injury or Covered sickness and performed by a Physician.

**Routine Eye Exam (Adult)** for routine vision examinations. Does not include the purchase or fitting of eyeglasses or contact lenses.

**Hearing Aid Benefit** for Insured Persons over age 18, as described in the Schedule of Benefits. Limits do not apply to enrolled Dependent Children.

#### **Mandated Benefits for Wisconsin**

**Mandate Disclaimer:** If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

**Home Health Care Expense** for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary.

**Skilled Nursing Facility Expense Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for custodial care or residential care is not covered.

**Cancer Clinical Trials** means clinical trials for the treatment of cancer or another life-threatening disease or condition. We will pay the Usual and Reasonable expenses incurred for Routine Patient Care in connection with the provision of goods, services, and benefits to such Insured Person in connection with approved clinical trial programs.

Cancer Clinical Trials must satisfy all of the following criteria:

- a. A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- b. The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- c. The trial has therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- d. The trial does one of the following:
  - 1) Tests how to administer a health care service, item, or drug.
  - 2) Tests responses to a health care service, item, or drug.
  - 3) Compares the effectiveness of health care services, items, or drugs for the treatment of cancer or another life-threatening disease or condition with that of other health care services, items, or drugs.
  - 4) Studies new uses of health care services, items, or drugs for the treatment of cancer.
- e. The trial is approved by one of the following:
  - 1) A National Institute of Health, or one of its cooperative groups or centers, under the federal department of health and human services.
  - 2) The federal food and drug administration.
  - 3) The federal department of defense.
  - 4) The federal department of veterans affairs.

For purposes of this Benefit:

**Routine Patient Care** means all health care services, items, and drugs for the treatment of cancer or another life-threatening disease or condition; all health care services, items, and drugs that are typically provided in health care, including health care services, items, and drugs provided to a patient during the course of treatment in clinical trials for a condition or any of its complications, and that are consistent with the usual and customary standard of care, including the type and frequency of any

diagnostic modality; Routine Patient Care specifically does not include the following: a health care service, item, or investigational drug that is the subject of the clinical trials; any health care service, item, or drug provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient; an investigational drug or device that has not been approved for market by the federal food and drug administration; transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that are associated with travel to or from a facility providing the clinical trials; any services, items, or drugs provided free of charge for any patient by the sponsors of the clinical trials; or any services, items, or drugs that are eligible for reimbursement by a person other than the insurer, including the sponsor of the clinical trials.

**Dental Anesthesia** for hospital or ambulatory surgery center charges incurred, and anesthetics provided, in conjunction with dental care that is provided to a covered individual in a hospital or ambulatory surgery center, if any of the following applies:

- a. The individual has a chronic disability that meets all of the following conditions:
  - 1) It is attributable to a mental or physical impairment or combination of mental and physical impairments.
  - 2) It is likely to contribute indefinitely.
  - 3) It results in substantial functional limitations in one or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; capacity for independent living; and economic self-sufficiency.
- b. The individual has a medical condition that requires hospitalization or general anesthesia for dental care.

**Kidney Disease Treatment** for dialysis, transplantation, and donor-related services.

**Hearing Aids and Cochlear Implants** for expenses incurred for hearing aids and cochlear implants prescribed by a Physician for an Insured Person who is under 18 years of age and who is certified as deaf or hearing impaired by a Physician. Eligible expenses include the cost of hearing aids and cochlear implants, including the cost of implantation of the cochlear devices.

**Diabetes Equipment and Supplies** used in the treatment of diabetes, including insulin and an insulin infusion pump. We may require the Insured Person to use an insulin infusion pump for 30 days prior to purchase. Benefit includes coverage for diabetic self-management education programs. Prescription Drugs used in the treatment of diabetes are covered under the Prescription Drug Benefit.

**Temporomandibular Joint Disorder (TMJ)** for the diagnosis and treatment of TMJ. Benefits are payable for diagnostic or surgical procedures involving a bone, joint, muscle, or tissue. We will provide coverage for diagnostic procedures and medically necessary surgical or nonsurgical treatment of TMJ if the following are true:

- a. The condition is caused by congenital, developmental, or acquired deformity, disease, or injury.
- b. The procedure or device is reasonable and appropriate for the diagnosis and treatment of TMJ.
- c. The purpose of the procedure or device is to control or eliminate infection, pain, disease, or dysfunction.

Nonsurgical treatment includes coverage for prescribed intraoral splint therapy devices.

This benefit does not include coverage for:

- a. Cosmetic or elective orthodontic care;
- b. Periodontic care;
- c. General dental care.

#### Section 4 – Accidental Death and Dismemberment Benefit

If, as the result of a covered Accident, an Insured Person sustains any of the following losses within the time shown in the Schedule of Benefits, We will pay the benefit shown.

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

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

#### Section 5– Exclusions and Limitations

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

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

1. **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
2. Preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.

3. Routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
4. Well baby care other than as shown in the Schedule of Benefits or under Child health Supervision Services.
5. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as provided in the Schedule of Benefits.
6. Dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to Sound, Natural Teeth or as specifically covered under the Policy.
7. Professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
8. Services or supplies not necessary for the medical care of Your Injury or Sickness.
9. Services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury or as specifically covered under the Policy.
10. Weak, strained or flat feet, corns, calluses or ingrown toenails.
11. Diagnostic or surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
12. Treatment or removal of nonmalignant moles, warts, boils, acne, actinic or seborrheic keratosis, dermatofibrosis or nevus of any description or form. Hallus valgus repair, varicosity, or sleep disorders including the testing for same.
13. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
14. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
15. Any expenses in excess of Usual and Reasonable charges.
16. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a 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 anywhere in the world.
17. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Insurance Information Schedule.
18. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;
19. treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
20. Services that are duplicated when provided by both a certified nurse-midwife and a Physician.
21. Expenses payable under any prior Policy which was in force for the person making the claim.
22. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
23. expenses incurred after:
  - The date insurance terminates as to the Insured Person; and
  - The end of the Benefit Period specified in the Benefit Schedule.
24. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
25. Charges incurred for acupuncture, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
26. Expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.
27. Expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses, except as required for repair caused by a Covered Injury or as specifically covered under the Policy.
28. racing or speed contests, skin diving, or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sailplaning, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
29. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
  - For the purposes of this provision, **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
  - For the purposes of this provision, **Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.
30. An Insured Person's:
  - committing or attempting to commit a felony,
  - being engaged in an illegal occupation, or

- participation in a riot.
31. Elective abortions in excess of the amount shown in the Schedule of Benefits.
  32. Custodial care service and supplies.
  33. Hernia, of any kind.
  34. Expenses that are not recommended and approved by a Physician.
  35. Bone anchored hearing aids unless Medically Necessary.
  36. Hearing aid batteries and cords.

**Third Party Refund – When:**

1. An Insured Student is injured through the negligent act or omission or another person (the “third party”); and
  2. Benefits are paid under the Policy as a result of that injury,
- We are entitled to a refund by the Insured Person of all Policy benefits paid as a result of the injury.

The refund must be paid to the extent that the Insured Person receives payment for the Injury from the third party or that third party’s insurance carrier. We may file a lien against that third-party payment. Reasonable pro-rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. The insured Person must complete and return required forms to Us upon request.

**Section 6 – CLAIM PROCEDURE**

In the event of Accident or Sickness the student should:

1. If at the College, report immediately to Health Services so that proper treatment can be prescribed or approved.
2. If away from the College, consult a doctor and follow his or her advice. Notify Your School within 90 days after the date of the Covered Injury or commencement of the Covered Sickness or as soon thereafter as is reasonably possible.
3. Secure a claim form from

**CONSOLIDATED HEALTH PLANS**  
 2077 Roosevelt Avenue  
 Springfield, MA 01104  
 Toll Free (877) 657-5030  
[www.studentinsurancechpstudent.com](http://www.studentinsurancechpstudent.com)

4. Complete the form.
5. Submit the claim form, complete with bills and receipts, to:

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

6. Submit only one claim form for each Accident or Sickness.

**Section 7 – Coordination of Benefits**

If the Insured Person is insured under more than one group health plan, the benefits of the plan that covers the Insured Student will be used before those of a plan that provides coverage as a dependent Insured Person. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy on file with the Policyholder.

**Section 8 - Appeals Procedure**

You have the right to appeal any decision or action taken by Us to deny, reduce, or terminate the provision of or payment for health care services requested or received under this Certificate of Insurance. You have the right to have Our decision reviewed by an independent review organization. We must provide you with certain written information, including the specific reason for Our decision and a description of Your appeals rights and procedures every time We make an determination to deny, reduce, or terminate the provision of or payment for health care services requested or received under the Certificate of Insurance.

*Service Representative:*  
**Claims Administrator:**  
**CONSOLIDATED HEALTH PLANS**  
 2077 Roosevelt Avenue



Springfield, MA 01104  
Toll Free (877) 657-5030  
[www.studentinsurancechpstudent.com](http://www.studentinsurancechpstudent.com)  
Group Number: ST0926SH

*Network Provider:*  
**Cigna**  
**PO Box 188061**  
**Chattanooga, TN 37422 – 8061**  
Electronic Payor ID: 62308

*Underwritten by:*  
National Guardian Life Insurance Company  
as policy form # NBH-280 (2016) WI

Administered by:  
**CONSOLIDATED HEALTH PLANS**  
2077 Roosevelt Avenue  
Springfield, MA 01104  
Toll Free (877) 657-5030  
[www.studentinsurance.com](http://www.studentinsurance.com)

**For a copy of the Company's privacy notice you may go to:**

[www.consolidatedhealthplan.com/about/hipaa](http://www.consolidatedhealthplan.com/about/hipaa)

or

*Request one from the Health Office at your School*

or

Request one from:

**National Guardian Life Insurance Company**  
**C/O Privacy Officer**  
**70 Genesee Street**  
**Utica, NY 13502**

(Please indicate the school you attend with your written request)

Note: The time you were covered under this plan may count as creditable coverage under State and Federal Law if you leave this plan and go to an employer's plan within 63 days thereafter. You are eligible to receive a certification from the Company regarding the periods you were covered. Please contact the Local Administrator listed in this brochure when you need such certification.

***Representations of this plan must be approved by Us.***

#### **IMPORTANT**

**THIS CERTIFICATE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE AS DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE AT THE COLLEGE.**



A Mutual Company Incorporated in 1909  
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-0826

The Policy to which this rider is attached is amended as follows:

**BENEFIT PAYMENT FOR NETWORK PROVIDERS AND NON-NETWORK PROVIDERS**

The policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. The policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits included in this Rider.

**SECTION I – DEFINITIONS** is amended by deleting the definition of “Covered Medical Expense”.

**SECTION I – DEFINITIONS** is amended by the addition of the following definitions:

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

1. Not in excess of the Usual and Reasonable charges therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the PPO Allowance;
4. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

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

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

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

**SECTION III - DESCRIPTION OF BENEFITS** is amended as follows:

The provision entitled Treatment of Covered Injury or Covered Sickness is amended to read:

**Treatment of Covered Injury or Covered Sickness**

We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to a Covered Injury or Covered Sickness. Benefits payable are subject to:

1. Any specified benefit maximum amounts;
2. Any Deductible amounts;
3. Any Coinsurance amount;
4. Any Copayments;
5. The Maximum Out-of-Pocket Expense Limit; and
6. Use of a Network Provider, if any.

The following provision is added:

**Preferred Provider Organization**

If an Insured Person uses a Network Provider, the policy will pay the Coinsurance percentage of the PPO Allowance shown in the Schedule of Benefits for Covered Medical Expenses.

If a Non-Network Provider is used, the policy will pay the percentage of the Usual and Reasonable Covered Medical Expense shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be the responsibility of the Insured Person.

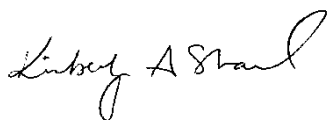
Note, however, that We will pay at the PPO Allowance level for treatment by a Non-Network Provider if:

1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.

An Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services from a Network Provider does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Physicians are Network Providers each time he or she calls for an appointment for at the time of service.

There are no other changes to the Policy.

This Rider is executed for the Company by its President and Secretary.



**Kimberly A. Shaul**  
Secretary



**Mark L. Solverud**  
President

**SCHEDULE OF BENEFITS**  
**Platinum Plan**

**Benefit Period:** When an Insured Person receives initial medical treatment within 30 days of the occurrence of a Covered Injury or at the onset of a Covered Sickness, eligible benefits will be provided for a continuous Benefit Period. The Benefit Period begins:

1. On the date of occurrence of such Covered Injury; or
2. From the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of the Policy Term (+ Extension of Benefits – when appropriate)

**Preventive Services:**

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

Non-Network: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum.

**Deductible:**

Network:	\$0
Non-Network:	\$0

**Out-of-Pocket Expense Limit:**

Network Provider:	\$3,000 Individual/ \$6,000 Family
Non-Network Provider:	\$10,000 Individual

**Coinsurance Amount:**

Network Provider:	100% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider:	80% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.

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

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

**PREFERRED PROVIDER ORGANIZATION:**

To locate a Cigna Provider in Your area, consult Your Provider Directory or call toll free 1-877-657-5030 or visit Our website at [www.studentinsurance.com](http://www.studentinsurance.com).

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

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
<b>Inpatient Benefits</b>		
Hospital Room & Board Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room & Board Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Preadmission Testing	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Physician’s Visits while Confined	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
<b>Inpatient Surgery:</b>		
Surgeon Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Anesthetist	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Assistant Surgeon	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
<b>Transplant Services:</b>		
Surgeon Services	Same as Inpatient Surgeon Services	\$30,000 per Policy Year for transplant surgery
Anesthetist	Same as Inpatient Anesthetist	
Assistant Surgeon	Same as Inpatient Assistant Surgeon	
<b>Congenital Heart Disease Surgery:</b>		
Surgeon Services	Same as Inpatient Surgeon Services	\$30,000 per Policy Year for congenital heart disease surgery
Anesthetist	Same as Inpatient Anesthetist	
Assistant Surgeon	Same as Inpatient Assistant Surgeon	

<b>BENEFITS FOR COVERED INJURY/SICKNESS</b>	<b>IN-NETWORK</b>	<b>NON-NETWORK</b>
Registered Nurse Services for private duty nursing while confined	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Physical Therapy (inpatient)	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy. Habilitative Services are covered to the extent that they are Medically Necessary at least 60 days per Policy Year	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
<b>Outpatient Benefits</b>		
Outpatient Surgery:		
Surgeon Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Anesthetist	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Assistant Surgeon	20% of benefits payable for Surgeon Services	20% of benefits payable for Surgeon Services
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy, speech therapy, and post-cochlear implant aural therapy  Habilitative Services are covered to the extent that they are Medically Necessary <ul style="list-style-type: none"> <li>▪ at least 20 visits per Policy Year</li> <li>▪ at least 40 visits per Policy Year if occupational therapy or physical therapy</li> <li>▪ at least 36 visits per Policy Year if cardiac rehabilitation</li> <li>▪ at least 30 visits per Policy Year if post-cochlear implant aural therapy</li> </ul>	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Emergency Services Expenses	100% of PPO Allowance for Covered Medical Expenses Copayment: \$100 Copayment waived if admitted.	100% of Usual and Reasonable charges for Covered Medical Expenses Copayment: \$100 Copayment waived if admitted.

<b>BENEFITS FOR COVERED INJURY/SICKNESS</b>	<b>IN-NETWORK</b>	<b>NON-NETWORK</b>
In Office Physician's Visits	The PPO Allowance stated above Copayment: \$25	The Usual and Reasonable Charge stated above Copayment: \$25
Urgent Care Centers or Facilities	The PPO Allowance stated above Copayment: \$50	The Usual and Reasonable Charge stated above Copayment: \$50
Diagnostic X-ray Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Laboratory Procedures (Outpatient)	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Prescription Drugs	100% of PPO Allowance for Covered Medical Expenses Copayment: \$15 Generic Copayment: \$30 Preferred Brand Copayment: \$50 Brand	N/A
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Home Health Care Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospice Care Coverage	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
<b>Other Benefits</b>		
Ambulance Service	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Braces and Appliances including Prosthesis and Orthotics	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Durable Medical Equipment	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Maternity Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Routine Newborn Care	Same as any other Covered Sickness.	Same as any other Covered Sickness.
Consultant Physician Services – when requested by the attending physician	The PPO Allowance stated above Copayment: \$40	The Usual and Reasonable Charge stated above Copayment: \$40
Accidental Injury Dental Treatment for Insured Persons over age 18  Subject to \$900.00 per tooth maximum \$3,000.00 per Policy Year	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Student Health Center/Infirmary Expense ( <i>Does not apply if no SHC</i> )	100% of Usual and Reasonable Charge for Covered Medical Expenses	
Sports Accident Expense – incurred as the result of the play or practice of Intercollegiate, intramural or club sports	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Abortion	No Benefit	No Benefit

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
<p><b>Pediatric Dental Care Benefit</b> Preventive Dental Care - limited to 1 dental exams every 6 months</p> <p><b>Other Pediatric Dental Care</b> <i>The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:</i></p> <ul style="list-style-type: none"> <li>• Emergency Dental</li> <li>• Clinical Oral Evaluations</li> <li>• Endodontic Services</li> <li>• Periodontal Services</li> <li>• Prosthodontic Services</li> <li>• Medically Necessary Orthodontic Care</li> </ul>	<p>See benefit for limitations 100% of PPO Allowance for Preventive Services</p> <p>50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable</p> <p>50% Usual and Reasonable</p>	<p>N/A</p>
<p><b>Pediatric Vision Care Benefit -</b> Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames.</p>	<p>100% of PPO Allowance for Covered Medical Expenses for Preventive Services</p>	<p>The Usual and Reasonable Charge stated above for Preventive Services</p>
<p>Chiropractic Care</p>	<p>The PPO Allowance stated above Copayment \$25</p>	<p>The Usual and Reasonable Charge stated above Copayment \$25</p>
<p>Routine Eye Exam (Adult) - limited to 1 exam per Policy Year.</p>	<p>The PPO Allowance stated above</p>	<p>The Usual and Reasonable Charge stated above</p>
<p>Hearing Aids (for Insured Persons over age 18)</p>	<p>The PPO Allowance stated above</p>	<p>The Usual and Reasonable Charge stated above</p>
<b>Mandated Benefits</b>		
<p>Home Health Care Expenses</p>	<p>The PPO Allowance stated above</p>	<p>The Usual and Reasonable Charge stated above</p>
<p>Skilled Nursing Facility Expense Benefit</p>	<p>The PPO Allowance stated above</p>	<p>The Usual and Reasonable Charge stated above</p>
<p>Cancer Clinical Trials</p>	<p>Same as any other Covered Sickness</p>	
<p>Dental Anesthesia</p>	<p>Same as any other Covered Sickness, subject to the limitations described in the Benefit</p>	
<p>Kidney Disease Treatment</p>	<p>Same as any other Covered Sickness, subject to the limitations described in the Benefit up to \$30,000 per Policy Year</p>	
<p>Hearing Aids and Cochlear Implant (for Insured Persons under age 18)</p>	<p>Same as any other Covered Sickness Limited to one hearing aid per ear per child every 3 years</p>	
<p>Diabetes Equipment and Supplies</p>	<p>Same as any other Covered Sickness Limited to one insulin infusion pump per year</p>	
<p>Temporomandibular Joint Disorder (TMJ)</p>	<p>Same as any other Covered Sickness \$1,250.00 per Policy Year for diagnostic procedures and non-surgical treatment</p>	





A Mutual Company Incorporated in 1909  
PO Box 1191 • Madison, WI 53701-1191

**AMENDMENT TO DEFINITIONS AMENDMENT**

This Amendment makes the revisions listed below to the Policy and Certificate to which it is attached.

The definition of Accident is deleted in its entirety and replaced with the following:

**Accident** means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

The definition of Covered Injury is deleted in its entirety and replaced with the following:

**Covered Injury** means a bodily injury that is caused by the Accident directly and independently of all other causes. Coverage under the School's policies must be in force on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

This Amendment is subject to all terms, conditions and provisions of the Policy/Certificate that are not inconsistent with it. Except as stated in this Amendment, it does not change or affect any other terms of the Policy and Certificate.

This Amendment takes effect on the same date as the Policy.

Signed for National Guardian Life Insurance Company, at its Home Office in Madison, Wisconsin.

**Kimberly A. Shaul**  
**Secretary**

**Mark L. Solverud**  
**President**



A Mutual Company Incorporated in 1909  
 PO Box 1191 • Madison, WI 53701-1191

Administrative Office:

**Consolidated Health Plans  
 2077 Roosevelt Avenue  
 Springfield, MA 01104**

**ADMINISTRATIVE CHANGE ENDORSEMENT**

**ENDORSEMENT SCHEDULE**

Policy Owner	Attached to Policy No.	Effective Date of Coverage
University of Wisconsin Colleges - International	2017I5B44	August 5, 2017

It is understood and agreed that the Policy to which this Endorsement is attached is amended as follows:

1. The Policy is amended to delete the following provision:

**Extension of Benefits:** Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended if an Insured Person is Hospital confined or Totally Disabled due to a Covered Injury or Covered Sickness. The coverage for the condition causing the Hospital confinement or Total Disability will be extended for up to a minimum of twelve (12) months from the Termination Date.

2. The Policy is amended to include the following provision:

**Extension of Benefits:** Coverage under this Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows:

1. If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to 90 days from the Termination Date while such confinement continues; or
2. If an Insured Person is Totally Disabled due to Covered Injury or Covered Sickness, the coverage for that condition will be extended for up to three months from the Termination Date.

In every other way, the Policy remains as is.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

President

X \_\_\_\_\_  
 Policy Owner's Signature  
 (If required by the Company)

\_\_\_\_\_  
 Countersignature of Licensed  
 Resident Agent, where required

## VALUE ADDED SERVICES

The following services are not part of the Plan Underwritten by National Guardian Life. These value-added options are provided by Consolidated Health Plans.

### VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:  
[www.studentinsurance.com](http://www.studentinsurance.com)

### EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 1.877.488.9833 or if you are in a foreign country, call +1.609.452.8570.** When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

### \*ASK MAYO CLINIC

Students who enroll and maintain medical coverage in this insurance plan have access to a 24-hour nurse line administered by *Ask Mayo Clinic*. This program provides:

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

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

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

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