**CASE WESTERN RESERVE UNIVERSITY \*\*UNIVERISTY HEALTH SERVICE \*\* 10900 EUCLID AVENUE\*\* CLEVELAND, OHIO 44106-4901\*\*(216) 368-2450**

**STUDENT MEDICAL PLAN/ PRACTICUM FALL 2021**

Please note while on practicum your tuition account is not automatically charged the Student Medical Plan fee. Please complete this form to join or decline enrollment in the Student Medical Plan.

\_\_\_\_\_ Yes I would like to be enrolled in the Student Medical Plan.

\_\_\_\_\_\_ I would like to decline participation in the Student Medical Plan because I already have health insurance coverage. I am currently insured with the following company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

My coverage meets the following waiver criteria listed below \_\_\_\_\_\_\_\_\_\_\_ (initial here)

Plan must be fully compliant with all coverage and consumer protection requirements outlined under the Patient Protection and Affordable Care Act.

1. Plan must be fully compliant with all coverage and consumer protection requirements outlined under the Patient Protection and Affordable Care Act (PPACA).
2. Coverage is currently active and the student agrees to maintain health coverage throughout the entire policy year.
3. Coverage for pre-existing conditions with no waiting period.
4. Plan provides coverage in Northeast Ohio or where enrolled in CWRU classes.
5. Plan provides emergency an non-emergency inpatient and outpatient (laboratory, diagnostic services, primary and specialty care and physical therapy) and inpatient and outpatient mental health/substance abuse as any other condition.
6. **International students** coverage must provide emergency medical evacuation coverage in the amount of at least $50,000 (medical evacuation is emergency transportation to the nearest, most qualified treatment facility).
7. **International students** coverage must provide at least $25,000 coverage for Repatriation (repatriation provides transportation to the student's home country in the event of death.

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student ID number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE UNIVERSITY HEALTH SERVICE BY SEPTEMBER 3, 2021.

**PLEASE REFER ANY QUESTIONS TO (216) 368-3049 OR MEDICALPLAN@CASE.EDU**