CASE WESTERN RESERVE UNIVERSITY

AMENDED AND RESTATED

MEDICAL CARE PLAN FOR STUDENTS AND THEIR DEPENDENTS

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

REVISED SEPTEMBER, 2017

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INTRODUCTION

The information contained in this document is a description of Case Western Reserve University Amended and Restated Medical Care Plan for Students and their Dependents **(**the "Plan") and defines how this Plan works. If you do not understand anything in this document, the Plan Administrator will be able to clarify any of your questions.

Case Western Reserve University fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, maximums, Copayments, exclusions, limitations, definitions, eligibility and the like.

This document provides details of a Participant's rights and benefits under the Plan. Please contact the University Health Services Department at Case Western Reserve University, 10900 Euclid Avenue, Cleveland, Ohio, 44106-4901 with any questions. You may also call University Health Services Department at (216) 368-3050.

ARTICLE I: PURPOSE OF PLAN

Case Western Reserve University hereby establishes this self-funded Plan to provide medical care benefits as set forth herein for the Participants. This self-funded Plan is a Plan to provide medical care benefits and is not medical insurance or a medical insurance plan.

ARTICLE II: CONSTRUCTION

The masculine gender, where appearing in the Plan, shall be deemed to include the feminine gender. The words "hereof", "herein", "hereunder", and other similar compounds of the word "here" shall mean and refer to the entire Plan and not to any particular provision or section.

ARTICLE III: NON-DISCRIMINATORY CLAUSES

The Case Western Reserve University Student Medical Plan (the Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, and other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Christopher Jones at Case Western Reserve University. If you believe that The Student Medical Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Christopher Jones, Assistant Vice President & Director of Equity, Case Western Reserve University, 10900 Euclid Avenue Cleveland, OH 44106, Phone: (216) 368-8877, Fax: (216) 368-8878, Email: christopher.jones3@case.edu.

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Christopher Jones is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Student Medical Plan does not discriminate against providers in regards to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.

If the Student Medical Plan provides coverage to a qualified individual, then the Plan will not deny the qualified individual participation in an approved clinical trial with respect to the treatment of cancer or another life-threatening disease, the Plan will not deny (or limit or impose additional conditions on) the coverage of routine patient costs for items and services furnished in connection with participation in the clinical trial, and will not discriminate against the individual on the basis of the individual's participation in the clinical trial.

ARTICLE IV: COMPREHENSIVE MEDICAL BENEFITS

4.1: Schedule of Medical Care Benefits for Plan Participants

This Plan utilizes the Aetna Student Health Network (Aetna). The Participating Provider Organization ("PPO") has contracted with health care Providers for services at a reduced fee. Participants of the Plan are encouraged to access a national network of Participating Providers in the Aetna network. Participants may realize substantial savings by utilizing Participating Providers. A directory of the Participating Providers in the network is accessible online.

The Plan, subject to the outlined benefits, limits and exclusions, protects the Participants during the term for which the fee has been paid. The Plan reserves the right to coordinate benefits with any other medical coverage.

Failure to utilize a network Provider will result in a benefit reduction of Covered Services.

In the case of a Medical Emergency as determined by the Claims Administrator, a Participant who obtains health care from a non- Pref Participating erred Provider will be subject to the in-network limits and restrictions with respect to such care. When Hospital or Medical Care is required because of Sickness or Injury eligible for benefits under this Plan, the Usual, Customary and Reasonable Charges, Fees and Expenses ("UCR") actually incurred will be paid, up to the specified limits.

POLICY YEAR MAXIMUM	**UNLIMITED**
DEDUCTIBLE: *Unless otherwise indicated, the Policy Year Deductible must be met prior to benefits being payable. In addition to state and federal requirements for waiver of the Policy Year Deductible, this Plan will waive the Deductible for: Participating Care and Non Participating care Preventive Care, Pediatric Vision Services, Participating Care Deductible (only) is waived for Pediatric Preventive Dental. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.*	
Individual	
Student:	*$250 per Policy Year*
Spouse/Domestic Partner:	*$250 per Policy Year*
Child:	*$250 per Policy Year*
Family	*$750 per Policy Year*
COINSURANCE: *Schedule of Medical Care Benefits Covered Medical Expenses are payable at the coinsurance percentage specified below, after any applicable Deductible.*	
OUT OF POCKET MAXIMUMS*: Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses and prescription expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the Out-of-Pocket Limit: expenses that are not covered medical expenses; any penalty amounts for Non-Precertification expenses for prescription drugs, penalties, and other expenses not covered by this Policy.*	
Participating Care	***Non- Participating Care***
Individual Out-of-Pocket	*Individual Out-of-Pocket*
$6,850 per Policy Year	*$15,000 per Policy Year*
Family Out-of-Pocket	*Family Out-of-Pocket*
$13,700 per Policy Year	*$20,000 per Policy Year*
The Out-of-Pocket limit includes any deductibles, co-payments and co-insurance amounts.	

Inpatient Hospitalization Benefits		
	Participating Care	***Non- Participating Care***
Room and Board Expense	***80%*** *of the Negotiated Charge* *70% Dependent Plan*	***60%*** *of the Recognized Charge for a semi-private room*
Miscellaneous Hospital Expense *Includes, but not limited to: operating room, laboratory tests/X rays, oxygen tent, and drugs, medicines, dressings.*	***80%*** *of the Negotiated Charge* ***70%*** *of the Negotiated Charge* *Dependent Plan*	***60%*** *of the Recognized Charge*
Non-Surgical Physicians Expense *Non-surgical services of the attending Physician, or a consulting Physician.*	***80%*** *of the Negotiated Charge* ***70%*** *of the Negotiated Charge* *Dependent Plan*	***60%*** *of the Recognized Charge*
Surgical Expenses		
	Participating Care	***Non- Participating Care***
Surgical Expense *(Inpatient and Outpatient)*	***80%*** *of the Negotiated Charge* ***70%*** *of the Negotiated Charge* *Dependent Plan*	***60%*** *of the Recognized Charge*
Anesthesia Expense *(Inpatient and Outpatient)*	***80%*** *of the Negotiated Charge* ***70%*** *of the Negotiated Charge* *Dependent Plan*	***60%*** *of the Recognized Charge*
Assistant Surgeon Expense *(Inpatient and Outpatient)*	***80%*** *of the Negotiated Charge* ***70%*** *of the Negotiated Charge* *Dependent Plan*	***60%*** *of the Recognized Charge*
Ambulatory Surgical Expense	***80%*** *of the Negotiated Charge* ***70%*** *of the Negotiated Charge* *Dependent Plan*	***60%*** *of the Recognized Charge*
Outpatient Expense		
	Participating Care	***Non- Participating Care***
Hospital Outpatient Department Expense	***80%*** *of the Negotiated Charge* ***70%*** *of the Negotiated Charge Dependent Plan*	***60%*** *of the Recognized Charge*
Walk-in Clinic Visit Expense	*After a* ***$20*** *Copay per visit, 80% of Negotiated Charge (waived if admitted)* *After a* ***$20*** *Copay per visit, 70% of Negotiated Chard (waived if admitted)Dependent Plan*	*After a* ***$20*** *Copay per visit, 60% of the Recognized Charge*
Emergency Room Expense ***Important Note:*** *Please note that Non-Participating Care Providers do not have a contract with Aetna; the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount*	*After a* ***$100*** *Copay per visit, 80% of Negotiated Charge (waived if admitted)* *After a $100 Copay per visit, 70% of Negotiated Charge (waived if admitted)Dependent Plan*	*After a $100 Copay per visit, 80% of Negotiated Charge (waived if admitted)* *After a $100 Copay per visit, 70% of Negotiated Charge (waived if admitted)* *Dependent Medical Plan*

*above your cost share, you are not responsible for paying that amount. Please send Aetna **t**he bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.*		
Urgent Care Expense	*After a **$30** Copay per visit, 80% of Negotiated Charge* *After a **$30**Copay per visit, 70% of Negotiated Charge Dependent Plan*	*After a **$30** Copay per visit, 60% of the Recognized Charge*
Ambulance Expense	***80%** of the Negotiated Charge* ***70%** of the Negotiated Charge Dependent Plan*	***80%** of the Recognized Charge* ***70%** of Recognized Charge Dependent Plan*
Physician's Office Visit Expense *This benefit includes visits to Specialists.*	*After a **$20** Copay per visit, 80% of Negotiated Charge* *After a **$20** Copay per visit, 70% of Negotiated Charge Dependent Plan*	*After a **$20** Copay per visit, 60% of the Recognized Charge*
Laboratory and X-ray Expense	***80%** of the Negotiated Charge* ***70%** of the Negotiated Charge Dependent Plan*	***60%** of the Recognized Charge*
High Cost Procedures Expense *Includes CT scans, MRIs, PET scans and Nuclear Cardiac Imaging Tests.*	***80%** of the Negotiated Charge* ***70%** of the Negotiated Charge Dependent Plan*	***60%** of the Recognized Charge*
Therapy Expense *Includes Physical, Speech, Habilitative, Rehabilitative Occupational Therapy*	***80%** of the Negotiated Charge* ***70%** of the Negotiated Charge Dependent Plan*	***60%** of the Recognized Charge*
Therapy Expense *Includes charges incurred by a covered person for the following types of therapy provided on an outpatient basis: Radiation therapy, Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy, Dialysis, and Respiratory therapy.*	*Covered Medical Expenses are payable on the same basis as any other covered person for the following Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Cardiac Rehabilitation Services—Outpatient	***80%** of the Negotiated Charge* ***70%** of the Negotiated Charge Dependent Plan*	***60%** of the Recognized Charge*
Pulmonary Rehabilitation Therapy	***80%** of the Negotiated Charge* ***70%** of the Negotiated Charge Dependent Plan*	***60%** of the Recognized Charge*
Chiropractic Therapy Expense	*After a **$20** Copay per visit, **80%** of Negotiated Charge* *After a **$20** Copay per visit, **70%** of Negotiated Charge*	*After a **$20** Copay per visit, 60% of the Recognized Charge*
Durable Medical and Surgical Equipment Expense	***80%** of the Negotiated Charge*	***60%** of the Recognized Charge*
Prosthetic Devices Expense	***80%** of the Negotiated Charge*	***60%** of the Recognized Charge*

Dental Injury Expense	***80%** of the Actual Charge*	
Allergy Testing and Treatment Expense	*Covered Medical Expenses are payable on the same basis as any other sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Diagnostic Testing For Learning Disabilities Expense *Once a covered person has been diagnosed with one of these conditions, medical treatment will be payable as detailed under the outpatient Treatment of Mental and Nervous Disorders portion of this Plan.*	*Covered Medical Expenses are payable on the same basis as any other sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Preventive		
	Participating Care	***Non- Participating Care***
Pap Smear Screening Expense	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Mammogram Expense *Includes one baseline mammogram for women between age 35 and 40. Coverage is also provided for one routine annual mammogram for women age 40 and older, as well as when medically indicated for women with risk factors who are under age 40. Risk factors for women under 40 are: Prior personal history of breast cancer, Positive Genetic Testings, Family history of breast cancer, or other risk factors.* *Mammogram screenings coverage must also include comprehensive ultrasound screening for the entire breast or breasts if a mammogram demonstrates heterogenous or dense breast tissue and when determined to be medically necessary by a licensed physician.*	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Immunizations Expense *Includes some travel immunizations and flu shots*	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Routine Physical Exam Expense *Includes routine tests and related lab fees*	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Routine Screening for Sexually Transmitted Disease Expense	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Routine Colorectal Cancer Screening Expense *Includes charges for colorectal cancer examination and laboratory tests, for any nonsymptomatic person age 50or more, or a symptomatic person under age 50, for the*	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*

following: One fecal occult blood test every 12 months in a row, a Sigmoidoscopy at age 50 and every 3 years thereafter, one digital rectal exam every 12 months in a row, a double contrast barium enema, once every 5 years, a colonoscopy, once every 10 years.		
Routine Prostate Cancer Screening *Includes charges incurred by a covered person for the screening of cancer as follows: for a male age 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year.*	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Pediatric Vision Care Exam Expense *Benefits are limited to 1 pair of glasses (lenses and frames) per Policy Year. Lenses include glass or plastic lenses including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses; polycarbonate prescription lenses with scratch resistance coating and low vision items. Covered Medical Expenses include routine vision exam (including refraction & glaucoma Testing), non-cosmetic eyeglass frames, prescription lenses or prescription contact lenses (not both).* *Benefits are provided to covered persons through age 18.*	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Pediatric Dental Care Expense	***100%** of the Negotiated Charge**	***60%** of the Recognized Charge*
Treatment of Mental and Nervous Disorders		
	Participating Care	***Non- Participating Care***
Inpatient Expense	***80%** of the Negotiated Charge*	***60%** of the Recognized Charge*
Outpatient Expense	*After a **$20** Copay per visit, 80% of Negotiated Charge*	*After a **$20** Copay per visit, 60% of the Recognized Charge*
Alcoholism and Drug Addiction Treatment		
	Participating Care	***Non- Participating Care***
Inpatient Expense	***80%** of the Negotiated Charge*	***60%** of the Recognized Charge*
Outpatient Expense	*After a **$20** Copay per visit, 80% of Negotiated Charge*	*After a **$20** Copay per visit, 60% of the Recognized Charge*

Maternity Benefits
Coverage for the Inpatient postpartum stay for you and your newborn child in a Hospital will be, at a minimum, 48 hours for a vaginal delivery and 96 hours for a cesarean section. Coverage will be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their Guidelines for Prenatal Care.

	Participating Care	***Non-Participating Care***
Maternity Expense	*Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Prenatal Care/Comprehensive Lactation Support Counseling Services	***100%*** *of the Negotiated Charge* *After a* ***$20*** *Copay per visit*	***60%*** *of the Recognized Charge*
Breast Feeding Durable Medical Equipment	***100%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Well Newborn Nursery Care Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Family Planning Expense	*Unless specified below, not covered under this benefit are charges for:* *-Services which are covered to any extent under any other part of this Plan;* *-Services and supplies incurred for an abortion;* *-Services provided as a result of complications resulting from a voluntary sterilization* *-Procedure and related follow-up care;* *-Services which are for the treatment of an identified illness or injury;* *-Services that are not given by a physician or under his or her direction;* *-Psychiatric,* *-Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA; Male* *contraceptive methods, or devices;* *-The reversal of voluntary sterilization procedures, including any related follow-up care*	
Voluntary Sterilization *Coverage for tubal ligation for voluntary sterilization*	***100%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Voluntary Sterilization *Coverage for vasectomy for voluntary sterilization*	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*

Prescription Coverage

- *Prior Authorization may be required for certain prescription drugs and some medication may not be covered under the Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, contact Aetna Pharmacy Management at (888) RX-AETNA (available 24 hours).*
- *Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information, go to www.aetnaspecialtyrx.com*

Participating Care
100% of the Negotiated Charge following a $15 Copay for each Generic Prescription Drug, a $40 Copay for each Formulary Brand Name Prescription Drug, or a $70 Copay for each Non-Formulary Brand Name Prescription Drug.

Non- Participating Care
60% of the Recognized Charge. Prescription must be paid out of pocket at a Non- Participating Pharmacy, and then the receipt, along with a Prescription Claim Form must be submitted for reimbursement.

- *80% of the Negotiated Charge for each Specialty Drug.*
- *Oral Chemotherapy must be payable on the same basis as IV Chemotherapy.*

Additional Benefits

	Participating Care	***Non-Participating Care***
Outpatient Diabetic Self-management Education Program Expense	*Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Temporomandibular Joint Dysfunction Expense	*Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Elective Abortion Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Hospice Benefit	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Home Health Care Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Licensed Nurse Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Skilled Nursing Facility Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Habilitation Facility Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Rehabilitation Facility Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Cochlear Implant Expense	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Foot Orthotics & Orthopedic Shoes Expense *Includes Medically Necessary foot orthotics and orthopedic shoes for covered persons with diabetes.*	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Private Duty Nursing Expense *Includes home nursing services provided through home health care. Limit applies to Private duty nursing in home setting.*	***80%*** *of the Negotiated Charge*	***60%*** *of the Recognized Charge*
Human Organ Transplants *Includes medically necessary Sickness, member cost sharing is based on the type of service performed and human organ and tissue the place of service where it is rendered transplant services. When a human organ or tissue transplant is provided from a living donor to a covered person, both the recipient and the donor may receive the benefits of the health Plan.*	*Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Human Organ Transplant- Transportation and Lodging *Includes assistance with reasonable and necessary travel expenses when patient is*	***100%*** *of the Actual Charge*	

required to travel more than 75 miles from residence to reach the facility where the Covered Transplant Procedure will be performed. Assistance with travel expenses includes transportation to and from the facility and lodging for the patient and one companion. If the Member receiving treatment is a minor, then reasonable and necessary expenses for transportation and lodging may be allowed for two companions. *Benefits are limited to **$10,000** per transplant benefit period.*		
Human Organ and Tissue Transplant Services - Unrelated donor search *Benefits are limited to **$30,000** per Transplant benefit period.*	*Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Biofeedback Expense	***80%** of the Negotiated Charge*	***60%** of the Recognized Charge*
Vision Correction after Surgery or Accident *Includes prescription glasses or contact lenses when required as a result of surgery or for the treatment of accidental injury.*	*Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Reconstructive Surgery *Includes necessary care and treatment of medically diagnosed congenital defects and birth abnormalities of a newborn child; Breast reconstruction resulting from a mastectomy; Hemangiomas, and port wine stains of the head and neck areas; Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly (supernumerary digits), macrodactylia; Otoplasty when performed to improve hearing by directing sound in the ear canal, when ear or ears are absent or deformed from trauma, surgery, disease, or congenital defect; Tongue release for diagnosis of tongue-tied; Congenial disorders that cause skull deformity such as Crouzon's disease; Cleft lip; Cleft palate.*	*Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	
Transgender Related Expense *Covered Medical Expenses include charges incurred by a covered person for medically necessary surgery, mental health, prescription drugs and other related services that are Covered Medical Expenses under this plan Surgical transgender services are limited to **$50,000** per Policy Year.*	*Covered Medical Expenses are payable on the same basis as any other Sickness, member cost sharing is based on the type of service performed and the place of service where it is rendered.*	

4.2: Pediatric Dental Benefits for Plan Participants
Diagnostic and Treatment Services
D0120 Periodic oral evaluation - Limited to 1 every 6 months
D0140 Limited oral evaluation - problem focused - Limited to 1 every 6 months
D0150 Comprehensive oral evaluation - Limited to 1 every 6 months
D0180 Comprehensive periodontal evaluation - Limited to 1 every 6 months
D0210 Intraoral – complete series (including bitewings) 1 every 60 (sixty) months
D0220 Intraoral - periapical first film
D0230 Intraoral - periapical - each additional film
D0240 Intraoral - occlusal film
D0270 Bitewing - single film Adult -1 set every calendar year / Children -1 set every 6 months
D0272 Bitewings - two films - Adult -1 set every calendar year / Children -1 set every 6 months
D0274 Bitewings - four films Adult -1 set every calendar year / Children -1 set every 6 months
D0277 Vertical bitewings – 7 to 8 films – Adult -1 set every calendar year / Children -1 set every 6 months
D0330 Panoramic film – 1 film every 60 (sixty) months
D0340 Cephalometric x-ray
D0350 Oral / Facial Photographic Images
D0470 Diagnostic Models *Note: Diagnostic procedures of: D0330, D0340, D0350 and D0470 are covered as Type A benefit and applied toward the Non-Ortho annual maximum for a non-vested orthodontia participant.*
Preventive Services
D1110 Prophylaxis – Adult - Limited to 1 every 6 months
D2150 Amalgam - two surfaces, primary or permanent;
D2160 Amalgam - three surfaces, primary or permanent;
D2161 Amalgam - four or more surfaces, primary or permanent;
D2910 Re-cement inlay;
D2920 Re-cement crown;
D2940 Protective Restoration;

D2951 Pin retention - per tooth, in addition to restoration;
D2140 Amalgam - one surface, primary or permanent;
D1120 Prophylaxis – Child - Limited to 1 every 6 months
D1203 Topical application of fluoride (excluding prophylaxis) – child - Limited to 2 every 12 months
D1204 Topical application of fluoride (excluding prophylaxis) – Age 15 to 22 - 2 every 12 months
D1206 Topical fluoride varnish - Over age 22 - 1 in 12 months; Less than age 22 - 2 in 12 months
D1351 Sealant - per tooth - unrestored permanent molars - Less than age 19. 1 sealant per tooth every 36 months
D1352 Preventative resin restorations in a moderate to high caries risk patient - permenant tooth - 1 sealant per tooth every 36 months
D1510 Space maintainer – fixed – unilateral - Limited to children under age 19
D1515 Space maintainer – fixed – bilateral - Limited to children under age 19
D1520 Space maintainer - removable – unilateral - Limited to children under age 19
D1525 Space maintainer - removable – bilateral - Limited to children under age 19
D1550 Re-cementation of space maintainer - Limited to children under age 19
Additional Procedures Covered as Basic Services
D9110 Palliative treatment of dental pain – minor procedure
Endodontic Services
D3220 Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately;
D3222 Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately;
D3230 Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime;
D3240 Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
D3346 Retreatment of previous root canal therapy-anterior;
D3347 Retreatment of previous root canal therapy-bicuspid;
D3348 Retreatment of previous root canal therapy-molar;
D3351 Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.);
D3352 Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.);
D3353 Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.);

D3354 Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration;
D3410 Apicoectomy/periradicular surgery – anterior;
D3421 Apicoectomy/periradicular surgery - bicuspid (first root);
D3425 Apicoectomy/periradicular surgery - molar (first root);
D3426 Apicoectomy/periradicular surgery (each additional root);
D3450 Root amputation - per root;
D3920 Hemisection (including any root removal) - not including root canal therapy;
Periodontal Services
D4341 Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
D4342 Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
D4910 Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active
D4240 Gingival flap procedure, four or more teeth – Limited to 1 every 36 months;
D4249 Clinical crown lengthening-hard tissue;
D4260 Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months;
D4270 Pedicle soft tissue graft procedure;
D4271 Free soft tissue graft procedure (including donor site surgery);
D4273 Subepithelial connective tissue graft procedures (including donor site surgery);
D4355 Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime;
Prosthodontic Services
D5410 Adjust complete denture – maxillary
D5411 Adjust complete denture – mandibular
D5421 Adjust partial denture – maxillary
D5422 Adjust partial denture - mandibular
D5510 Repair broken complete denture base
D5520 Replace missing or broken teeth - complete denture (each tooth)
D5610 Repair resin denture base

D5620 Repair cast framework
D5630 Repair or replace broken clasp
D5640 Replace broken teeth - per tooth
D5650 Add tooth to existing partial denture
D5660 Add clasp to existing partial denture
D5710 Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5720 Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5721 Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5730 Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5731 Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5740 Reline maxillary partial denture - Limited to 1in a 36-month period 6 months after the initial installation
D5741 Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
D5750 Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5751 Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5760 Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
D5761 Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
D5850 Tissue conditioning (maxillary)
D5851 Tissue conditioning (mandibular)
D6930 Recement fixed partial denture
D6980 Fixed partial denture repair, by report
D5130 Immediate denture - maxillary – Limited to 1 every 60 months;
D5140 Immediate denture - mandibular – Limited to 1 every 60 months;
D6010 Endosteal Implant - 1 every 60 months;
D6012 Surgical Placement of Interim Implant Body - 1 every 60 months;
D6040 Eposteal Implant – 1 every 60 months;
D6050 Transosteal Implant, Including Hardware – 1 every 60 months;

D6053 Implant supported complete denture;
D6054 Implant supported partial denture;
D6055 Connecting Bar – implant or abutment supported - 1 every 60 months;
D6056 Prefabricated Abutment – 1 every 60 months;
D6078 Implant/abutment supported fixed partial denture for completely edentulous arch- 1 every 60 months;
D6079 Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months;
D6080 Implant Maintenance Procedures -1 every 60 months;
D6090 Repair Implant Prosthesis -1 every 60 months;
D6091 Replacement of Semi-Precision or Precision Attachment -1 every 60 months;
D6095 Repair Implant Abutment -1 every 60 months;
D6100 Implant Removal -1 every 60 months;
D6190 Implant Index -1 every 60 months;
D6210 Pontic - cast high noble metal – Limited to 1 every 60 months;
D6211 Pontic - cast predominately base metal – Limited to 1 every 60 months;
D6212 Pontic - cast noble metal– Limited to 1 every 60 months;
D6214 Pontic – titanium – Limited to 1 every 60 months;
D6240 Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months;
D6241 Pontic - porcelain fused to predominantly based metal – Limited to 1 every 60 months;
D6242 Pontic - porcelain fused to noble metal – Limited to 1 every 60 months;
D6245 Pontic - porcelain/ceramic – Limited to 1 every 60 months;
D6519 Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months;
D6520 Inlay – metallic – two surfaces – Limited to 1 every 60 months;
D6530 Inlay – metallic – three or more surfaces - Limited to 1 every 60 months;
D6543 Onlay – metallic – three surfaces - 1 every 60 months;
D6544 Onlay – metallic – four or more surfaces -1 every 60 months;
D6973 Core buildup for retainer, including any pins - 1 every 60 months; and,

D9940 Occlusal guard, by report - 1 in 12 months for patients 13
Oral Surgery
D7140 Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
D7210 Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
D7220 Removal of impacted tooth - soft tissue
D7230 Removal of impacted tooth – partially bony
D7240 Removal of impacted tooth - completely bony
D7241 Removal of impacted tooth - completely bony with unusual surgical complications
D7250 Surgical removal of residual tooth roots (cutting procedure)
D7251 Coronectomy - intentional partial tooth removal
D7270 Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
D7280 Surgical access of an unerupted tooth
D7310 Alveoloplasty in conjunction with extractions - per quadrant
D7311 Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7320 Alveoloplasty not in conjunction with extractions - per quadrant
D7321 Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
D7471 Removal of exostosis
D7510 Incision and drainage of abscess - intraoral soft tissue
D7910 Suture of recent small wounds up to 5 cm
D7971 Excision of pericoronal gingiva
Class B Intermediate
D2330 Resin–based composite - one surface, anterior;
D2331 Resin-based composite - two surfaces, anterior;
D2332 Resin-based composite - three surfaces, anterior;
D2335 Resin-based composite - four or more surfaces or involving incisal angle (anterior);
D2930 Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months;

D2931 Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months;
Class C Major
D0160 Detailed and extensive oral evaluation - problem focused, by report;
D2510 Inlay - metallic – one surface – An alternate benefit will be provided;
D2520 Inlay - metallic – two surfaces – An alternate benefit will be provided;
D2530 Inlay - metallic – three surfaces – An alternate benefit will be provided;
D2542 Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months;
D2543 Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months;
D2544 Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months;
D2950 Core buildup, including any pins– Limited to 1 per tooth every 60 months;
D2954 Prefabricated post and core, in addition to crown– Limited to 1 per tooth every
D2980 Crown repair, by report;
D2740 Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
D2750 Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
D2751 Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
D2752 Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
D2780 Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months;
D2781 Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months
D2783 Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months;
D2790 Crown - full cast high noble metal – Limited to 1 per tooth every 60 months
D2791 Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months
D2792 Crown - full cast noble metal – Limited to 1 per tooth every 60 months;
D2794 Crown – titanium – Limited to 1 per tooth every 60 months;
D3310 Anterior root canal (excluding final restoration);
D3320 Bicuspid root canal (excluding final restoration);
D3330 Molar root canal (excluding final restoration);

D4210 Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months;
D4211 Gingivectomy or gingivoplasty – one to three teeth;
D5110 Complete denture - maxillary – Limited to 1 every 60 months;
D5120 Complete denture - mandibular – Limited to 1 every 60 months; rests and teeth) – Limited to 1 every 60 months;
D5211 Maxillary partial denture - resin base (including any conventional clasps,
D5212 Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5213 Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5214 Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months;
D5281 Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months;
D6058 Abutment supported porcelain ceramic crown - 1 every 60 months;
D6059 Abutment supported porcelain fused to high noble metal - 1 every 60 months;
D6060 Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months;
D6061 Abutment supported porcelain fused to noble metal crown - 1 every 60 months;
D6062 Abutment supported cast high noble metal crown - 1 every 60 months;
D6063 Abutment supported cast predominately base metal crown - 1 every 60 months;
D6064 Abutment supported cast noble metal crown - 1 every 60 months;
D6065 Implant supported porcelain/ceramic crown - 1 every 60 months;
D6066 Implant supported porcelain fused to high metal crown - 1 every 60 months;
D6067 Implant supported metal crown - 1 every 60 months;
D6068 Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months;
D6069 Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months;
D6070 Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months;
D6071 Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months;
D6072 Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months;
D6073 Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months;
D6074 Abutment supported retainer for cast noble metal fixed partial denture – 1 every 60 months;

D6075 Implant supported retainer for ceramic fixed partial denture - 1 every 60 months;
D6076 Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months;
D6077 Implant supported retainer for cast metal fixed partial denture - 1 every 60 months;
D6545 Retainer - cast metal for resin bonded fixed prosthesis - 1 every 60 months;
D6548 Retainer - porcelain/ceramic for resin bonded fixed prosthesis - 1 every 60 months;
D6740 Crown - porcelain/ceramic - 1 every 60 months;
D6750 Crown - porcelain fused to high noble metal - 1 every 60 months;
D6751 Crown - porcelain fused to predominately base metal - 1 every 60 months;
D6752 Crown - porcelain fused to noble metal - 1 every 60 months;
D6780 Crown - 3/4 cast high noble metal - 1 every 60 months;
D6781 Crown - 3/4 cast predominately base metal - 1 every 60 months;
D6782 Crown - 3/4 cast noble metal - 1 every 60 months;
D6783 Crown - 3/4 porcelain/ceramic - 1 every 60 months;
D6790 Crown - full cast high noble metal - 1 every 60 months;
D6791 Crown - full cast predominately base metal - 1 every 60 months;
D6792 Crown - full cast noble metal - 1 every 60 months; and,
Class D Orthodontic
D8010 Limited orthodontic treatment of the primary dentition
D8020 Limited orthodontic treatment of the transitional dentition
D8030 Limited orthodontic treatment of the adolescent dentition
D8050 Interceptive orthodontic treatment of the primary dentition
D8060 Interceptive orthodontic treatment of the transitional dentition
D8070 Comprehensive orthodontic treatment of the transitional dentition
D8080 Comprehensive orthodontic treatment of the adolescent dentition
D8210 Removable appliance therapy
D8220 Fixed appliance therapy

D8660 Pre-orthodontic treatment visit
D8670 Periodic orthodontic treatment visit (as part of contract)
D8680 Orthodontic retention (removal of appliances, construction and placement of retainer(s)
Note: Benefits for codes D0330, D0340, D0350, and D0470 will be applied to the lifetime orthodontia maximum when performed as part of orthodontia treatment; for those dependents eligible for Class D benefits who have satisfied the 24 month orthodontic waiting period for services rendered on or after 1/1/2012.
Services Not Covered
Orthodontic care for dependent children age 19 and over
Orthodontic care for members and spouses
Repair of damaged orthodontic appliances
Replacement of lost or missing appliance
Orthodontic services provided to a dependent of an enrolled member who has not met the 24 month waiting period requirement.
Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
D7292 Surgical replacement screw retained
D7293 Surgical replacement w/surgical flap
D7294 Surgical replacement without the surgical flap
D7880 TMJ Appliance
D7899 TMJ Therapy
D7951 Sinus Augmentation with bone or bone substitutes
D7997 Appliance Removal
D7998 Intraoral placement of a fixation device
D0320 TMJ arthrogram
D0321 Other TMJ films
D0322 Tomographic survey
D0360 Cone Beam CT
D0362 Cone Beam multiple images 2 dim
D0363 Cone Beam multiple images 3 dim
D0416 Viral culture

D0418 Analysis of saliva example chemical or biological analysis of saliva for diagnostic purposes.
D0425 Caries test
D0431 Adjunctive pre-diagnostic test
D0475 Declassification procedure
D0476 Special stains for microorganisms
D0477 Special stains not for microorganisms
D0478 Immunohistochemical stains
D0479 Tissue in-situ-hybridization
D0481 Electron microscopy
D0482 Direct immunofluorescence
D0483 In-direct immunofluorescence
D0484 Consultation on slides prepared elsewhere
D0485 Consultation including preparation of slides
D0486 Accession Transepithelial
D1310 Nutritional counseling
D1320 Tobacco counseling
D1330 Oral Hygiene Instruction
D1555 Removal of fixed space maintainer
D2410 Gold Foil 1 surface
D2420 Gold Foil 2 surface
D2430 Gold Foil 3 surface
D2799 Provisional Crown
D2955 Post Removal
D2970 Temporary Crown
D2975 Coping
D3460 Endodontic Implant

D3470 Intentional reimplantation
D3910 Surgical procedure for isolation of tooth
D3950 Canal preparation
D4230 Anatomical crown exposure 4 or more teeth
D4231 Anatomical crown exposure 1-3 teeth
D4320 Splinting intracoronal
D4321 Splinting extracoronal
D5810 Complete denture upper (interim)
D5811 Complete denture lower (interim)
D5820 Partial denture upper (interim)
D5821 Partial denture lower (interim)
D5862 Precision Attachment
D5867 Replacement Precision Attachment
D5986 Fluoride Gel Carrier
D6057 Custom abutment
D6253 Provisional Pontic
D6254 Interim pontic
D6795 - Interim retainer crown
D6920 Connector bar
D6940 Stress breaker
D6950 Precision Attachment
D6975 Coping - metal
D9210 Local Anesthesia not in conjunction with operative or surgical procedures
D9211 Regional Block Anesthesia
D9212 Trigeminal Division Block Anesthesia
D9215 Local Anesthesia

D9230 Analgesia, anxiolysis, inhalation of nitrous oxide
D9248 Non-intravenous conscious sedation
D9410 House / extended care facility call
D9420 Hospital Call
D9450 Case presentation
D9630 Other drugs and or medicaments
D9920 Behavior Management
D9941 Fabrication of athletic mouthguard
D9950 Occlusion analysis - mounted case
D9951 Occlusal adjustment - limited
D9952 Occlusal adjustment - complete
D9970 Enamel microabrasion
D9971 Odontoplasty 1-2 teeth
D9972 External bleaching - per arch
D9973 External bleaching - per tooth
D9974 Internal bleaching - per tooth
D0310 Sialography
D0472 Oral Pathology lab
D0473 Oral Pathology lab
D0474 Oral Pathology lab
D0480 Oral Pathology lab
D0502 Oral Pathology lab
D5911 Facial Moulage (sectional)
D5912 Facial Moulage (complete)
D5913 Nasal Prosthesis
D5914 Auricular Prosthesis

D5915 Orbital Prosthesis
D5916 Ocular Prosthesis
D5919 Facial Prosthesis
D5922 Nasal Septal Prosthesis
D5923 Ocular Prosthesis (interim)
D5924 Cranial Prosthesis
D5925 Facial Augmentation implant
D5926 Nasal Prosthesis (replacement)
D5927 Auricular Prosthesis (replacement)
D5928 Orbital Prosthesis (replacement)
D5929 Facial Prosthesis (replacement)
D5931 Obturator Prosthesis (surgical)
D5932 Obturator Prosthesis (definitive)
D5933 Obturator Prosthesis (modification)
D5934 Mandibular resection Prosthesis w/guide flange
D5935 Mandibular resection Prosthesis w/out guide flange
D5936 Obturator Prosthesis (interim)
D5937 Trismus Appliance
D5951 Feeding Aid
D5952 Speech Aid prosthesis (pediatric)
D5953 Speech Aid prosthesis (adult)
D5954 Palatal Augmentation Prosthesis
D5955 Palatal Lift Prosthesis (definitive)
D5958 Palatal Lift Prosthesis (interim)
D5959 Palatal Lift Prosthesis (modification)
D5960 Speech Aid Prosthesis (modification)

D5982 Surgical Stent
D5983 Radiation Carrier
D5984 Radiation Shield
D5985 Radiation Cone locator
D5987 Commissure Splint
D5988 Surgical Splint
D5992 Adjust maxillofacial prosthetic appliance, by report
D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
D7285 Biopsy of oral tissue (hard)
D7286 Biopsy of oral tissue (soft)
D7295 Harvest of bone for use in autogenous grafting procedures
D7410 Lesion up to 1.25 (benign)
D7411 Lesion greater than 1.25 (benign)
D7412 Complicated lesion (benign)
D7413 Lesion up to 1.25 (malignant)
D7414 Lesion greater than 1.25 (malignant)
D7415 Complicated lesion (malignant)
D7440 Lesion diameter up to 1.25 (malignant)
D7441 Lesion diameter greater than 1.25 (malignant)
D7460 Removal of Benign lesion up to 1.25
D7461 Removal of Benign lesion greater than 1.25
D7465 Destruction of lesion (by report)
D7490 Radical resection upper/lower
D7530 Removal of foreign body
D7540 Removal of reaction producing the foreign body
D7550 Partial Ostectomy

D7560 Maxillary Sinusotomy
D7610 Upper open reduction
D7620 Upper closed reduction
D7630 Lower open reduction (simple)
D7640 Lower closed reduction (simple)
D7650 Open reduction (simple)
D7660 Closed reduction (simple)
D7670 Alveolus closed reduction (simple)
D7671 Alveolus open reduction (simple)
D7680 Facial bones (simple)
D7710 Upper open reduction (compound)
D7720 Upper closed reduction (compound)
D7730 Lower open reduction (compound)
D7740 Lower closed reduction (compound)
D7750 Malar and/or zygomatic arch open red.(compound)
D7760 Malar and/or zygomatic arch closed red.(compound)
D7770 Alveolus open red.(compound - stabilization of teeth)
D7771 Alveolus closed red. (compound – stabilization of teeth)
D7780 Facial bones (compound)
D7810 TMJ open reduction
D7820 TMJ closed reduction
D7830 TMJ manipulation
D7840 Condylectomy
D7850 Surgical discectomoy
D7852 Disc repair
D7854 Synovectomy

D7856 Myotomy
D7858 Joint reconstruction
D7860 Arthrotomy
D7865 Arthroplasty
D7870 Arthrocentesis
D7871 Non-Arthroscopic
D7872 Arthroscopy with or without a biopsy
D7873 Arthoscopy surgical adhesions
D7874 Arthoscopy surgical disc
D7875 Arthoscopy surgical synovectomy
D7876 Arthoscopy surgical discectomy
D7877 Arthoscopy surgical debridement
D7911 Complicated sutures up to 5 cm.
D7912 Complicated sutures greater than 5 cm.
D7920 Skin graft
D7940 Osteoplasty deformities
D7941 Osteotomy lower rami
D7943 Osteotomy lower rami with bone graft
D7944 Osteotomy segmented
D7945 Osteotomy body of mandible
D7946 Lefort I upper total
D7947 Lefort I upper segmented
D7948 Lefort II or Lefort III without bone graft
D7949 Lefort II or Lefort III with bone graft
D7950 Bone graft - mandible or face
D7955 Repair of Maxillofacial soft or hard tissue

D7980 Sialolithotomy
D7981 Excision of salivary gland
D7982 Sialodochoplasty
D7983 Closure of salivary fistula
D7990 Emergency tracheotomy
D7991 Coronoidectomy
D7995 Synthetic graft
D7996 Implant lower for augmentation purposes
Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist. In these states, we will pay for eligible covered services provided by an authorized dental hygienist performing within the scope of his or her license and applicable state law;
Services and treatment which are experimental or investigational;
Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available, in whole or in part, under the provision of any law or regulation or any government unit. This exclusion applies whether or not you claim the benefits or compensation;
Services and treatment received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, VA hospital or similar person or group;
Services and treatment performed prior to your effective date of coverage;
Services and treatment incurred after the termination date of your coverage unless otherwise indicated;
Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice.
Services and treatment resulting from your failure to comply with professionally prescribed treatment;
Telephone consultations;
Any charges for failure to keep a scheduled appointment;
Any services that are considered strictly cosmetic in nature including, but not limited to, charges for personalization or characterization of prosthetic appliances;
Services related to the diagnosis and treatment of Temporomandibular Joint Dysfunction (TMD);
Services or treatment provided as a result of intentionally self-inflicted injury or illness;
Services or treatment provided as a result of injuries suffered while committing or attempting to commit a felony, engaging in an illegal occupation, or participating in a riot, rebellion or insurrection;
Office infection control charges;
Charges for copies of your records, charts or x-rays, or any costs associated with forwarding/mailing copies of your records, charts or x-rays;
State or territorial taxes on dental services performed;
Those submitted by a dentist, which is for the same services performed on the same date for the same member by another dentist;

Those provided free of charge by any governmental unit, except where this exclusion is prohibited by law;
Those for which the member would have no obligation to pay in the absence of this or any similar coverage;
Those which are for specialized procedures and techniques;
Those performed by a dentist who is compensated by a facility for similar covered services performed for members;
Duplicate, provisional and temporary devices, appliances, and services;
Plaque control programs, oral hygiene instruction, and dietary instructions;
Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth;
Gold foil restorations;
Treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid or payable under a plan or policy of motor vehicle insurance, including a certified self-insurance plan;
Treatment of services for injuries resulting from war or act of war, whether declared or undeclared, or from police or military service for any country or organization;
Hospital costs or any additional fees that the dentist or hospital charges for treatment at the hospital (inpatient or outpatient);
Charges by the provider for completing dental forms;
Adjustment of a denture or bridgework which is made within 6 months after installation by the same Dentist who installed it;
Use of material or home health aids to prevent decay, such as toothpaste, fluoride gels, dental floss and teeth whiteners;
Sealants for teeth other than permanent molars;
Precision attachments, personalization, precious metal bases and other specialized techniques;
Replacement of dentures that have been lost, stolen or misplaced;
Orthodontic services provided to a dependent of an enrolled member who has not met the 24 month waiting period requirement.
Orthodontic care for dependent children age 19 and over;
Repair of damaged orthodontic appliances;
Replacement of lost or missing appliances;
Fabrication of athletic mouth guard;
Internal bleaching;
Nitrous oxide;
Oral sedation;
Topical medicament center

Orthodontic care for a member or spouse
Bone grafts when done in connection with extractions, apicoetomies or non-covered/non eligible implants.
When two or more services are submitted and the services are considered part of the same service to one another the Plan will pay the most comprehensive service (the service that includes the other non-benefited service).
When two or more services are submitted on the same day and the services are considered mutually exclusive (when one service contradicts the need for the other service), the Plan will pay for the service that represents the final treatment.
All out of network services listed in Section 5 are subject to the usual and customary maximum allowable fee charges. The member is responsible for all remaining charges that exceed the allowable maximum.

4.3: Preventive Health Services

PPACA Preventive Care Benefits are provided at 100% percent reimbursement as specified in the Schedule of Benefits for services received at Case Western Reserve University Health Services and services received at in-network providers as specified in this section.

The Student Medical Plan also provides certain preventive care benefits and services that exceed requirements of the PPACA; these benefits and services are provided in the section entitled Covered Services/Expenses, and are provided pursuant to the Schedule of Benefits.

PPACA Preventive Care Benefits are subject to change, pursuant to determinations by the U.S. Department of Health and Human Services and the U.S. Preventive Services Task Force. Refer to the Student Medical Plan website or to the following websites for updates and the full list of covered Preventive Care Benefits:

https://www.cdc.gov/vaccines/hcp/acip-recs/index.html

https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/

Quick Reference of Some Covered Preventive Services for Adults (NOTE: THIS IS NOT AN EXHAUSTIVE LIST):

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked
- Alcohol Misuse screening and counseling
- Aspirin to prevent cardiovascular disease in men and women
- Blood Pressure screening for all adults
- Cholesterol screening for adults of certain ages or at higher risk
- Colorectal Cancer screening for adults over 50
- Depression screening for adults
- Falls prevention in older adults (exercise or physical therapy)
- Falls prevention in older adults (vitamin D)
- Lung Cancer Screening
- Obesity screening and counseling for adults
- Skin Cancer Behavioral Counseling
- Sexually transmitted infections (STI) prevention counseling for adults at higher risk
- Tobacco use and screening for all adults and cessation interventions for tobacco users
- Type 2 Diabetes screening for adults with high blood pressure
- Diet counseling for adults at higher risk for chronic disease
- HIV screening for all adults at higher risk
- Hepatitis B screening: nonpregnant adolescents and adults
- Hepatitis C virus infection screening: adults
- HIV screening: nonpregnant adolescents and adults
- Syphilis screening
- Zoster (Shingles) vaccination
- Immunization vaccines for adults--doses, recommended ages, and recommended populations vary:
    - Hepatitis A

- Hepatitis B
- Herpes Zoster
- Human Papillomavirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Tetanus, Diphtheria, Pertussis
- Varicella

Quick Reference of Some Covered Preventive Services for Women, Including Pregnant Women (NOTE: THIS IS <u>NOT</u> AN EXHAUSTIVE LIST):

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women at higher risk
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women
- Cervical Cancer screening for sexually active women
- Chlamydia Infection screening for younger women and other women at higher risk
- Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs
- Domestic and interpersonal violence screening and counseling for all women
- Folic Acid supplements for women who may become pregnant
- Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women
- Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older
- Osteoporosis screening for women over age 60 depending on risk factors
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling for pregnant tobacco users
- Sexually Transmitted Infections (STI) counseling for sexually active women
- Syphilis screening for all pregnant women or other women at increased risk
- Well-woman visits to obtain recommended preventive services for women under 65
- Covered Preventive Services for Children
- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children of all ages Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Blood Pressure screening for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Depression screening for adolescents
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk of lipid disorders Ages: 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening for all newborns

- Height, Weight and Body Mass Index measurements for children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathies or sickle cell screening for newborns
- HIV screening for pregnant women including those who present in labor who are untested and whose HIV status is unknown
- Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary:
- Diphtheria, Tetanus, Pertussis
- Haemophilus influenzae type b
- Hepatitis A
- Hepatitis B
- Human Papillomavirus
- Inactivated Poliovirus
- Influenza (Flu Shot)
- Measles, Mumps, Rubella
- Meningococcal
- Pneumococcal
- Rotavirus
- Varicella
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Obesity screening and counseling
- Oral Health risk assessment for young children Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years.
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling and screening for adolescents at higher risk
- Tobacco use counseling and interventions for pregnant women, children and adolescents
- Tuberculin testing for children at higher risk of tuberculosis Ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.
- Vision screening for all children
- Preeclampsia prevention: aspirin
- Syphilis screening
- Intimate partner violence screening: women of childbearing age

4.4: Coinsurance Percentages

The Plan shall pay the percentage of the Usual, Customary and Reasonable Charges, Fees and Expenses for any Covered Medical Expenses as stated in the applicable Schedule of Benefits. The Participant is responsible for the remaining percentage up to the maximum Out-of-Pocket Limit.

4.5: Student Contributions

The fee for the Case Western Reserve University Medical Plan for Students is charged per semester. This fee does not include any Coinsurance percentage or Copayments which may be incurred by the Participant.

4.6: Maximum Out-of-Pocket Limit

When, in a Plan Year, a Participant has incurred medical expenses in the amount equal to the Out-of-Pocket Limit for Covered Medical Expenses not payable under this Plan due to percentages less than 100%, the Plan shall then pay up to negotiated charges or UCR of Covered Medical Expenses incurred beyond the maximum Out-of-Pocket Limit for the remainder of that Benefit Year.

4.7: Covered Medical Expenses

A. Inpatient Hospital expenses
   1. Room and Board Charges;
   2. Operating, delivery and treatment rooms and equipment;
   3. Intensive care, cardiac care or other similar necessary care;
   4. Private duty nursing by a Registered Graduate Nurse other than a nurse who is a member of the Participant's family or his Spouse's family;
   5. Miscellaneous Charges; and
   6. Private room is covered when only single rooms are available or if Medically Necessary.

B. Extended Care Facility charges provided
   1. The Participant must first be confined in a Hospital for at least three (3) days or the stay must be determined to be Medically Necessary rather than for Custodial Care;
   2. A Physician recommends confinement for convalescence from the condition or related condition which caused the Hospital confinement;
   3. The Participant is under the continuous care of a Physician during the entire period of confinement;
   4. The Participant commences his stay in the Extended Care Facility within fourteen (14) days following discharge from the Hospital.
   5. Eligible Extended Care Facility charges shall be:
   6. Room and Board Charges; and
   7. Miscellaneous Charges, not including any charges for professional services ordered by a Physician and furnished by the facility for Inpatient care

C. Outpatient Hospital expenses:
   1. Diagnostic tests and x-rays;
   2. Pre-operative, operative and post-operative services;
   3. Miscellaneous Charges;
   4. Emergency room in cases of Medical Emergency; and

D. Surgical Expenses

   Surgery includes the Medically Necessary pre-operative and post-operative care, when performed by a Physician. Services are subject to Pre-Certification review procedures as detailed in Article V.

   If two (2) or more operations or procedures are performed on the same day, on the same patient, by the same Physician, benefits are as described in the Schedule of Benefits and are subject to the Usual, Customary and Reasonable Charges**,** Fees and Expenses**,** or other negotiated rate, for the first procedure, and 50% of Usual, Customary and Reasonable Charges, Fees and Expenses or other negotiated rate, for any additional procedures.

   Surgical Assistance Service: Medically Necessary service of one (1) Physician who actively assists the operating surgeon when a covered Surgery is performed in a Hospital, and when such surgical assistance service is not available by an intern, resident or house Physician. The Plan provides benefits equal to 20% of the allowance for the Surgery, not to exceed the Physician's actual charge.

   Anesthesia Service: Service rendered by a Physician or a Certified Registered Nurse Anesthetist, other than by the attending surgeon or his assistant, and includes the administration of spinal or rectal anesthesia, or a drug or other anesthetic agent by injection or inhalation, except by local infiltration. Additional benefits are not provided for pre-operative Anesthesia consultation.

   Outpatient Surgery: A Participant receiving services in a Hospital, but not admitted as a registered bed-patient, is entitled to a benefit equal to the Hospital's UCR charges for the covered benefits furnished him, but only for the following:
   a. Hospital care for accidental Injury including x-ray and lab services provided on the same day as treatment;
   b. Use of the Hospital's facilities and equipment for Surgery, including x-ray and lab services provided on the same day as Surgery;
   c. Use of the Hospital's facilities and equipment for radiation therapy, inhalation therapy and

physical therapy;

d. Benefits will be provided for the initial treatment of a Medical Emergency;
e. Charges incurred for a second and/or third Surgical Opinion;
f. Elective abortions for participating Students, Spouse, Domestic Partner or Dependent;
g. Oral Surgery due to accidental Injury to sound, natural teeth.

E. Professional Services
1. Physician services for performing or assisting in the performance of Surgery or an obstetrical procedure, home, office and Hospital visits and other Medical Care and treatment;
2. Charges for an elective second Surgical Opinion or third Surgical Opinion to either confirm or deny proposed Surgery. A second or third Surgical Opinion must be given by:
a. A board certified internist; or
b. A board certified specialist in the appropriate specialty;
3. Anesthesia and its administration;
4. Diagnostic X-ray or laboratory examinations and their interpretation;
5. Outpatient pre-admission testing;
6. Chiropractic medical care, treatment, and X-rays as listed in the Schedule of Benefits;
7. Maternity Benefits:
a. Expenses for participating Students, Spouse, Domestic Partner, and Dependents;
b. Expenses are covered on the same basis as Sickness;
c. Birthing Center services or Nurse-Midwives/Practitioners for Medically Necessary services in connection with delivery of a Child or Children provided in state certified Birthing Centers. The Nurse-Midwife/Practitioner must be licensed for the nature of services provided by the state he or she is operating in;
d. Inpatient charges for a newborn baby for routine nursery room and board and for routine professional services required for the newborn. Routine nursery benefits are limited to the period of the mother's confinement and will be considered for payment as an eligible expense under the newborn Participant when added to the Plan as described under the heading "Participation."

NOTE: If the expenses for a newborn are not for well-baby services, all eligible expenses will be considered under the newborn Participant when added to the Plan as described under the heading "Participation."

8. Therapeutic treatment:
a. Physiotherapy provided by a Physician, Hospital or legally qualified physiotherapist;
b. Speech therapy by a qualified speech therapist required because of an Injury or Sickness other than a functional nervous disorder; provided, however, if therapy is required because of a congenital anomaly, the Participant must have had corrective Surgery before the therapy. Expenses related to special educational needs are not covered.
c. Radiation therapy;
d. Chemotherapy;
e. Occupational therapy;
f. Respiratory therapy;
g. Rehabilitative therapy.
h. Cardiac rehabilitation must be rendered under the supervision of a Physician, be initiated within twelve (12) weeks after other treatment for the medical condition ends, and services must be rendered in a Medical Care facility as defined by the Plan; and
i. Kidney Dialysis.

F. Office visits and audiological testing for the diagnosis of hearing loss;
G. Mental/Nervous Disorders and Alcoholism and Drug Addiction Treatment

The Plan will pay eligible expenses for Inpatient and outpatient treatment of Mental/Nervous Disorders and Alcoholism and Drug Addiction Treatment as detailed in the Schedule of Benefits. The unpaid balance of these expenses will not count toward the maximum Out-of-Pocket Limitation. The maximum amount payable on account of all Covered Medical Expenses incurred with respect to any one (1) Participant is listed in the Schedule of Benefits.

The provisions concerning Mental/Nervous Disorders and Alcoholism and Drug Treatment apply only to services resulting from diagnosis or recommendation by a Physician and only to expenses to the extent that they

are for treatment recognized by the medical profession as appropriate methods of treatment in accordance with broadly accepted standards of medical practice, taking into account the current condition of the individual. Expenses incurred for treatment of Mental/Nervous Disorders and Alcoholism and Drug Treatment will be considered as Covered Medical Expenses only as provided above and listed in the Schedule of Benefits.

Eligible Providers are M.D.s, Ph.D.s, psychologists or licensed social workers, licensed professional counselors, therapists or mental health nurse specialists if services are provided under the supervision of an M.D. or Ph.D., or a licensed Psychiatrist or psychologist.

H. Home Health Care Expenses
Charges by a Home Health Care Agency for visits furnished to a Participant in such person's home in accordance with covered benefits are eligible if:

1. The attending Physician certifies that:
    a. Hospitalization or confinement in an Extended Care Facility would otherwise be required if home care were not available;
    b. Medically Necessary Care and treatment are not available from members of the Participant's immediate family or other person residing with the Participant without causing undue hardship; and
    c. The services are provided or coordinated by a Home Health Care Agency.
2. The Home Health Care must be Medically Necessary. The following services and supplies are covered:
    a. Nutrition counseling provided by or under the supervision of a registered dietitian;
    b. Part-time or intermittent nursing care by a Registered Graduate Nurse or, if the services of a Registered Graduate Nurse are not available, by a licensed practical nurse;
    c. Physical, occupational, respiratory, or speech therapy; and
    d. Medical supplies, drugs and medications prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, if such supplies and services would be covered under the Plan if the Participant were Hospital confined.
3. The Home Health Care benefit shall not cover:
    a. Services or supplies not approved by the Utilization Review Service;
    b. Services rendered in any period during which the Participant is not under the continuing care of a Physician;
    c. Services of a person who ordinarily resides in the Participant's home or is a member of the family of the patient/Participant;
    d. The services of any social worker;
    e. Transportation services;
    f. Custodial Care; and
    g. Care for a Child or family member while caretaker is ill.
4. Each visit by a home health aide of up to four (4) consecutive hours in a twenty-four (24) hour period shall be considered as one (1) Home Health Care visit.

I. Hospice benefits shall be as follows:
Terminally Ill Patient

1. In order to be eligible for this hospice benefit, the Terminally Ill Patient must be confined in a Hospital for at least three (3) days in connection with the terminal illness immediately prior to participating in a hospice program. The hospice benefit pays Usual, Customary and Reasonable Charges, Fees and Expenses provided such charges are incurred during the period of participation in the Plan. Covered Medical Expenses must be incurred for services provided for the Family Unit of the Participant under the Hospice program of care that are rendered by a Hospice Care Agency or other facility on behalf of the Hospice Care Agency.
2. Covered hospice expenses include:
    a. Inpatient hospice care;
    b. Physicians' services;
    c. Home Health Care services, including:
        i. Part-time nursing care rendered in the Participant's home;
        ii. Physician's visits to the Participant's home;
        iii. Physical therapy provided in the Participant's home;

iv. The use of medical equipment;
v. The rental of wheelchairs and Hospital type beds;
vi. Emotional support services of a Physician or social worker;
vii. Drugs and medication; and
viii. Homemaker services.

J. Prescribed Medicines Expense:
Prior Authorization may be required for certain prescription drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, contact Aetna Pharmacy Management at 888 RX-AETNA (available 24 hours).

Aetna Specialty Pharmacy provides specialty medications and support to members living with chronic conditions. The medications offered may be injected, infused or taken by mouth. For additional information go to www.AetnaSpecialtyRx.com

Participating Care
1. 100% of the Negotiated Charge following a $15 Copay for each Generic Prescription Drug, a $40 Copay for each Formulary Brand Name Prescription Drug, or a $70 Copay for each Non-Formulary Brand Name Prescription Drug.

Non-Participating Care:
2. 60% of the Recognized Charge.
3. Prescriptions must be paid out of pocket at a Non- Participating Pharmacy, and then the receipt along with a Prescription Claim Form must be submitted for reimbursement.
4. 80% of the Negotiated Charge for each Specialty Drug.
5. Oral Chemotherapy must be payable on the same basis as IV Chemotherapy.

K. Other eligible medical expenses:
1. Local professional ambulance service for necessary transportation due to an accident or life threatening emergency or for treatment which cannot be performed at the Hospital in which the patient is confined;
2. Air ambulance, if determined to be Medically Necessary, to the nearest facility where care can be provided;
3. Diagnostic infertility tests for determination of the physiological condition and treatment of the medical condition if it is causing the infertility problem;
4. Medically Necessary charges for gastric bypass Surgery:
Before proceeding with a gastric procedure, the Participant shall be actively engaged in a disease management program for obesity for a minimum of six (6) months. This program should be supervised by a Physician and include nutrition and exercise, including dietitian consultation, low calorie diet, increase physical activity and behavioral modification. This program must be documented in a medical record including:
a. Regular monthly Physician visits;
b. Participation in nutrition and exercise program that is supervised by a Physician working in cooperation with dietitians and/or nutritionists;
c. Healthy activity with supervised exercise three (3) to five (5) times a week;
d. Participation in the nutrition and exercise program must occur within the two (2) years prior to Surgery.
5. If the Participant fails to achieve a 10% reduction in BMI, he/she may be eligible for the gastric bypass Surgery if BMI >35 with co-morbidities or BMI >40.
Surgical Preparation**:**
1. The Participant must enter a dedicated bariatric program with dietary/nutrition and psychological/psychiatric preoperative evaluation;
2. The program must address long-term lifestyle management;
3. The need for the Surgery must be documented by a Physician other than the surgeon for the bariatric procedure;
4. Weight loss dietary and exercise program must occur for a minimum of six (6) months or longer, must be within the two (2) years prior to Surgery and must be documented in a medical record, not a summary letter from the Physician;
5. Morbid Obesity must have existed for five (5) years prior to surgical consideration as documented by Physician records.

6. Allergy injections**,** testing and vials/medication;
7. Necessary Durable Medical Equipment rental, up to the amount of purchase of such equipment;
8. Preventive care as described in the Schedule of Benefits;
9. Biofeedback as listed in the Schedule of Benefits;
10. Transplants are reviewed with regard to Medical Necessity, the facility's recommendations and Physician documentation. Any services and supplies that are required for donor/procurement as a result of a surgical transplant procedure for a Participant will be provided up to the maximum limitation listed in the Schedule of Benefits. This limitation applies to all donor/procurement charges. Benefits for such charges, services and supplies are not provided under this provision if benefits are provided under another group plan or any other group or individual contract or any arrangement of coverage for individuals in a group (whether an insured or uninsured basis), including any prepayment coverage;
11. Confinement in a rehabilitation facility must follow within twenty-four (24) hours of and be for the same or related cause(s) of a period of Hospital or Extended Care Facility confinement;
12. Reconstruction of the breast on which a mastectomy was performed, Surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complications at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending Physician;
13. Pain management for chronic pain must be Medically Necessary and rendered by a covered Physician. Pain is chronic if it has occurred recurrently over months or years or persists longer than expected following a Sickness or Injury. Typically, pain is not considered chronic until it has persisted for three (3)–six (6) months or more. Multiple disciplinary pain management assessment and the submission of a treatment plan following the initial evaluation by a pain Physician will be required for pain management services. Prior Authorization is required;
14. Medically Necessary Care and treatment;
15. Orthotics, which require a prescription from a Physician and the orthotic is made specifically for that Participant; and
16. Prosthetic devices, which includes the replacement due to growth, psychological change or change in the Participant's condition.

4.8: Exclusions and Limitations

The following services or charges shall not be considered Covered Medical Expenses under the Plan:

A. Transportation charges other than by a professional ambulance service;
B. Services rendered after termination of participation in the Plan;
C. Services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with Custodial Care, education, or training, or expenses actually incurred by other persons except as specifically addressed under Covered Medical Expenses;
D. Services needed due to war or any act of war, whether declared or undeclared;
E. Services rendered resulting from or occurring during the commission of a crime or while engaged in an illegal act. Exclusion will not apply to injuries and/or illnesses sustained due to a medical condition (physical or mental) or domestic violence;
F. Services, care, treatment, and referrals rendered by the Participant's family including, but not limited to, mother, father, grandmother, grandfather, aunt, uncle, cousin, brother, sister, son, daughter, grandson, granddaughter, or any person who resides with the Participant;
G. Services rendered for treatment of any Sickness or Injury for which benefits are available under any workers' compensation employer liability law or services for any occupational Sickness or Injury. Occupational Sickness or Injury includes those as a result of any work for wage or profit;
H. Charges for completion of claim forms;
I. Charges billed by both Physician and Hospital for the same service (except for charges for Anesthesia which shall be paid to the Hospital and to the Physician based upon Usual, Customary and Reasonable Charges, Fees and Expenses);
J. Expenses in excess of the Usual, Customary and Reasonable Charges, Fees and Expenses;
K. Education classes, including charges for natural childbirth instruction;
L. Services performed for cosmetic or reconstructive Surgery or complications of cosmetic or reconstructive Surgery procedures unless:

2. The condition is necessary as the result of an accident or sickness;
3. Scar revision due to an accident or Sickness.
4. Correction of congenital defects which interferes with bodily function;
5. The services are performed during the period a Participant is participating under the plan,
6. The services are for reconstruction of the breast on which a mastectomy was performed, Surgery and reconstruction of the breast on which a mastectomy was performed, Surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complications at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending physician.

M. Services performed for cosmetic or reconstructive Surgery or complications of cosmetic or reconstructive Surgery procedures unless the services are performed during the period a Participant is participating under the Plan and:
1. The condition is necessary as the result of accident or Sickness;
2. Scar revision due to accident or Sickness;
3. Correction of congenital defects which interferes with bodily function;
4. The services are for reconstruction of the breast on which a mastectomy was performed, Surgery and reconstruction of the other breast to achieve symmetry in appearance and necessary prosthesis or physical complications at any stage of mastectomy, including lymphedemas. These procedures shall be performed in a manner determined in consultation with the patient and the patient's attending Physician.

N. Any related expenses for a procedure not covered by the Plan;

O. Charges which are payable by any third party due to legal liability including, but not limited to, professional liability insurance, motor vehicle liability insurance, individual liability insurance, and any other source from which medical benefits would be paid if this Plan did not exist, whether or not legal action is taken on behalf of the Participant;

P. Charges which the Participant would not be required to pay if he did not have health coverage;

Q. Charges to the extent of coverage required by, or available through, any federal, state, municipal or other governmental body or agency, except as provided in paragraph 4.9 and except for medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Medicaid");

R. Experimental/Investigative drugs, chemicals, services or procedures, except where covered in the policy**.**

S. Services provided by an entity not defined as an eligible Provider;

T. Music therapy, vision therapy or remedial reading therapy.

U. Exercise equipment including bicycles, weights, ergometers, or other equipment not generally considered Durable Medical Equipment;

V. Charges and services related to a newborn who is not a participating Dependent;

W. Dental expenses except as specifically outlined in the Schedule of Benefits;

X. Reversal of sterilization for participating Student, Spouse, Domestic Partner or Dependent

Y. Services or supplies rendered or furnished in a military or veterans administration Hospital, unless rendered in connection with a Disability which is not in any way related to the participating Student's military service;

Z. With respect to diagnostic testing:
1. Tests performed more frequently than is necessary according to the diagnosis and accepted medical practice;
2. Genetic testing unless family history necessitates;
3. Premarital examinations;
4. Duplicate testing by different Physicians unless second opinions are authorized herein; and
5. Tests associated with routine visits except those covered under the wellness benefit provision.

AA. With respect to consultations:
1. Telephone only consultations;
2. Consultations for ineligible or unnecessary procedures; and
3. Services rendered by practitioners other than Physicians.

BB. With respect to infertility:
1. Invitro or invivo fertilization, artificial insemination, or any other impregnation procedure;
2. Fertility drugs;
3. Any treatment other than that which treats a medical condition;
4. Diagnostic tests unless necessary to diagnose a medical condition; and
5. Fertility supplies, treatment and counseling.

CC. With respect to Hospital services:
1. Room and Board Charges made by a facility other than a Hospital or Extended Care Facility;
2. Admissions for observation, rest, physical therapy, or testing;
3. Weekend admissions except for Medical Emergencies;
4. Charges for any period of confinement prior to the day before scheduled Surgery unless a documented hazardous medical condition exists; and
5. Charges deemed not Medically Necessary by the Claims Administrator.

DD. Transplant expenses incurred for donor procurement to the extent exceeding the limits set forth in the Schedule of Benefits and the list of Covered Medical Expenses;

EE. Visual acuity testing, visual correction other than cataract removal, by any means, including radial keratotomy, lasik Surgery and other Surgeries, exercise, eyeglasses, contact lenses, or orthoptic training;

FF. Penile implants and/or any related expenses unless having organic origin;

GG. Arch supports and orthopedic shoes except as specifically addressed in the Schedule of Benefits.

HH. Hearing aids

II. Acupuncture or hypnotherapy;

JJ. Medical care claims filed more than twelve (12) months from the date of service;

KK. Care and treatment that is deemed not Medically Necessary;

LL. Taxes, postage, shipping and handling; and

MM. For removal of excess skin unless Medically Necessary.

NN. For all NCAA Sanctioned Intercollegiate Sports Injuries, the Plan is primary for the first $90,000 of eligible expense per injury and secondary to coverage provided under the NCAA catastrophic policy.

ARTICLE V: PARTICIPATION

5.1: Eligibility for Benefits

Individuals eligible to enroll in the Plan include:

1. A Student of Case Western Reserve University registered for at least one (1) credit hour;
2. Persons associated with Special Programs on the campus of Case Western Reserve University may be eligible for this Student coverage as determined by the Plan Administrator;
3. A Student of The Cleveland Institute of Art or The Cleveland Institute of Music registered for at least one (1) credit hour.
4. The Spouse or Dependent of a participating Student.

NOTE: The following individuals are not eligible to receive this coverage even if they meet the above noted criteria:

1. A Student cross-registered for classes at Case Western Reserve University or its affiliates; and
2. Employees of Case Western Reserve University who are eligible for Benelect.
3. Students enrolled in virtual and online classes.

Medicare Eligibility Notice: If a **covered person** becomes eligible for **Medicare** after he or she is enrolled in the Policyholder's plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under the plan. As used within this provision, persons are "eligible for **Medicare"** if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Upon enrollment in the Plan pursuant to this section and payment of any required Student Contribution, the Student and, if applicable, his Dependent(s) shall become Participants eligible to receive benefits as provided by this Plan.

Your eligible dependents may participate in the Student Medical Plan, provided you are also currently a participant. Eligible dependents include any of the following:

- Your lawful spouse as defined by applicable state law.
- Your domestic partner, as defined by Case Western Reserve University
- A child younger than age 26.

For purposes of the Student Medical Plan, child means any of the following relationships to a covered student:

- Your natural child, including any child for whom you are required to provide coverage under a court order.
- A legally adopted child by you and a child for whom you are the proposed adoptive parent and who has been placed in your care and custody during the waiting period before the adoption becomes final.
- A child of your domestic partner.
- A stepchild.
- A foster child.

If you and your spouse or domestic partner are both students, only one of you may cover a dependent child. In addition, you may not participate in the Student Medical Plan as both a student and a dependent at the same time.

5.2: Enrollment

A Student is enrolled in the Plan by the University based on the eligibility requirements in Section 4.1.

Participation in the Plan by the Student and, if applicable, his Dependent(s), shall be contingent upon receipt by the University of a completed enrollment form and any other information requested by the University and, if applicable, payment of any required Student Contribution; provided, however, eligibility to enroll shall not be based on any of the following health-status related factors in relation to the Student or his Dependent(s): (a) health status; (b) medical condition (including both physical and mental illness); (c) claims experience; (d) receipt of health care; (e) medical history; (f) genetic information; (g) evidence of insurability (including conditions arising out of acts of domestic violence); or (h) disability.

If a Student enrolls in the Plan pursuant to this section, the Student and, if applicable, his Dependent(s), shall become Participants effective the day of enrollment at the beginning of the respective semester.

5.3: Special Enrollment Procedure

A. **Individuals Losing Other Coverage**: The Plan shall permit a Student who is eligible for coverage under the terms of the Plan but not enrolled (or a Dependent of such a Student if the Dependent is eligible for coverage under the Plan but not enrolled) to enroll for coverage under the Plan pursuant to this section if each of the following conditions is met:

1. The Student or Dependent was covered under another Health Plan or otherwise had Health Insurance Coverage at the time coverage under the Plan was previously offered to the Student or Dependent;
2. The Student stated in writing at such time that he had coverage under a Health Plan or otherwise had Health Insurance Coverage and that such coverage was the reason for declining enrollment; provided, however, this condition shall apply only if the Plan Sponsor required such a statement at the time coverage under the Plan was offered and provided the Student with notice of such requirement and the consequences of failing to enroll at such time;
3. The Student's or Dependent's coverage described in subparagraph (A)(1) of this section: (i) was under a COBRA Continuation Provision and the coverage under such provision was exhausted; or (ii) was not under a COBRA Continuation Provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including, but not limited to, as a result of legal separation, divorce, death, termination of enrollment, reduction in the number of hours of enrollment, the operation of a lifetime limit on all benefits, and in the case of group coverage provided through an HMO an individual no longer resides, lives, or works in the service area of the HMO [whether or not within the choice of the individual]); and
4. The Student requests special enrollment under this section not later than thirty (30) days after the date of exhaustion of coverage described in subparagraph (A)(3)(i) of this section or the date of termination of coverage or Plan Sponsor contribution described in subparagraph (A)(3)(ii) of this section.

B. **Dependent Beneficiaries**

1. If a Student eligible to participate in the Plan is a Participant (or has met any Waiting Period applicable to becoming a Participant) and is eligible to be enrolled under the Plan but for a failure to enroll during a previous enrollment period, and he acquires a Dependent through marriage, birth or adoption or

Placement for Adoption, the following special enrollment period set forth in subparagraph (B)(2) of this section shall apply during which period such Student and Dependent may be enrolled under the Plan, and in the case of the birth or adoption of a Child, the Spouse of the Student may also be enrolled as a Dependent of such Student if otherwise eligible.

2. The Dependent special enrollment period shall be a period of not less than thirty (30) days and shall begin on the later of: (i) the date Dependent coverage is made available under the Plan, or (ii) the date of the marriage, birth or adoption or Placement for Adoption, as the case may be, as described in subparagraph (B)(1) above of this section.
3. If a Student described in subparagraph (B)(1) of this section seeks to enroll a Dependent during the first thirty (30) days of the Dependent special enrollment period, the coverage of the Dependent shall become effective: (i) in the case of marriage, as of the date of marriage; (ii) in the case of a Dependent's birth, as of the date of such birth; or (iii) in the case of Dependent's adoption or Placement for Adoption, as of the date of such adoption or Placement for Adoption.
4. If applicable, upon the enrollment of a Dependent under this Section 4.3 B., the Student may change Plan options, if any. Amounts incurred to satisfy deductibles and Out-of-Pocket Limits, if any, will be applied to the new option.

5.4: Medical Leave of Absence Policy

A participating Student may continue coverage while out on a personal medical leave of absence. A Student must meet the following requirements:

- Enrolled in the Plan the previous semester;
- Approval from the Student's school for the personal medical leave of absence;
- Documentation from the medical provider/counselor or therapist confirming the medical necessity of the leave;
- Application, documentation and payment must be submitted to the Student Medical Plan Department prior to the drop/add date for the semester for which the request is made.

When a Student is on a personal medical leave of absence, payment of the Plan fee allows coverage under the Student Medical Plan only, subject to the exclusions and limitations of the Plan.

5.5: Coverage Changes Due to a Life Event

In addition to the special enrollment procedures set forth in Section 4.3 above, a participating Student may change coverage from single to family or from family to single when there is a (Life Event) by notifying the University Health Services department within thirty-one (31) days of the Life Event.

The effective date of the change in coverage will be the date of the Life Event;

A. Change in Legal Marital Status. Events that change a Student's legal marital status, including the following: marriage, death of Spouse, divorce, legal separation and annulment.
B. Number of Dependents. Events that change a Student's number of Dependents, including the following: birth, death, adoption and Placement for Adoption.
C. Change in Employment Status. Any of the following events that change the employment status of the Student, his Spouse, or Dependent: a termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, change in worksite or change in employment status with the consequence of the individual becoming (or ceasing to be) eligible under an employer's group health plan.
D. Dependent Satisfies or Ceases to Satisfy Eligibility Requirement. Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage.
E. Open Enrollment. The Student's plan or Spouse's plan holds an open enrollment.

If necessary, an updated health care identification card will be issued upon receipt of revised Student data relating to the Life Event.

5.6: Enrollment Pursuant to Qualified Medical Child Support Orders

Notwithstanding anything herein to the contrary, any Child of a Student, Spouse or their Domestic Partner participating in the Plan shall be enrolled in the Plan in accordance with the terms of any Qualified Medical Child Support Order. Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Orders from the Benefit Committee.

5.7: Termination of Participation

The participation of a Student and/or Dependent(s) in the Plan shall terminate as follows:

Student Participation: Subject to the provisions of Section 4.2, the participation of a Student in the Plan shall terminate upon the first occurrence of any of the following events:

- A Student no longer meets the definition of Student as set forth in Article XIV, for any reason;
- Termination of the Plan; or the Student fails to make any required Student Contributions.

Dependent Participation: Subject to the provisions of Section 4.5, the participation of a Dependent in the Plan shall terminate upon the first occurrence of any of the following events:

- The Dependent no longer meets the definition of Dependent as set forth in Article XIV;
- The Student ceases being a Participant in the Plan;
- Participation for Dependents in the Plan is terminated;
- The Dependent commences participation in the Plan as an Student; or
- Any required contributions are not made.

5.8: Continuation of Coverage (COBRA)

Case Western Reserve University Medical Care Plan is not subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

5.9: Integration with Medicare

Students or Spouses who are 65 years of age or older have a choice regarding health care coverage. Such Students or Spouses may elect to participate in the Plan, or reject such participation and choose Medicare.

Students or Spouses who are 65 years of age or older have a choice regarding health care coverage. Such Students or Spouses may elect to participate in the Plan, reject such participation and choose Medicare, or enroll in both Medicare and the Plan if eligible.

A. **Plan as Primary Payor**. If the Student or Spouse chooses the Plan as the primary payor, the Plan shall pay the same benefits as if the Student or Spouse were under age 65, and any unpaid medical expenses may be coordinated with Medicare; however, Medicare shall be the primary payor for Students and Dependents participating in the Plan who are eligible for Medicare benefits and are not employees of the University.
B. **Medicare**. If the Student or Spouse rejects the Plan, Medicare shall be the only payor and the Plan shall not pay benefits. Medicare shall be the primary payor for Participants who are eligible for Medicare and Medicare disability benefits. Benefits will be coordinated with any other eligible Medicare plan or coverage so that combined payments under all programs will not exceed 100% of allowable expenses incurred for covered services and supplies.
C. **End Stage Renal Disease**. If a participating Student or Dependent becomes eligible for Medicare on the basis of end-stage renal (kidney) disease (ESRD), then the Plan will be the primary payor for the applicable coordination period as it is then defined under federal law (currently thirty (30) months for individuals who become Medicare eligible due to ESRD on or after October 31, 1997), and Medicare will be secondary. After the expiration of the coordination period, Medicare will be the primary payor and the Plan will be secondary. Provided, however, that if Medicare is already the primary payor (on the basis of age or disability) for a Participant who becomes eligible for Medicare due to ESRD, then Medicare will remain the primary payor.

ARTICLE VI: PRIOR AUTHORIZATION OF SERVICES

6.1: Scope of Prior Authorization Review

Benefits payable under the Plan relating to those services identified in Section 5.2, paragraph B, are subject to the Pre-Certification review procedures. Benefits shall be payable only for Covered Medical Expenses and the Pre-Certification review procedures shall not in any manner be construed as expanding the benefits payable under the Plan.

Participants are required to obtain pre-certification by calling (877) 850-6038 or (TDD) (800) 466-5996 before receiving the following services:

- Elective Surgery
- MRI Scan
- CAT Scar Retrograde
- Transgender surgery

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (non-emergency transportation);
- Autologous chondrocyte implantation, Carticel®
- Bariatric surgery (bariatric surgery is not covered under the Policy unless specifically described in the Policy.);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;
- Electric or motorized wheelchairs and scooters;
- Gender Reassignment (Sex Change) Surgery;
- Home health care related services (ie. private duty nursing),
- Hyperbaric oxygen therapy;
- Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy.)
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment;
- Kidney dialysis;
- Knee surgery;
- Limb Prosthetics;
- Out-of-network freestanding ambulatory surgical facility services when referred by a network provider;
- Oncotype DX;
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Osseointegrated implant;
- Osteochondral allograft/knee;
- Outpatient back surgery not performed in a physician’s office;

- Pediatric Congenital Heart Surgery;
- Pre-implantation genetic testing;
- Procedures that may be considered cosmetic. Cosmetic services and supplies are not covered under the plan unless specifically described in the Policy;
- Proton beam radiotherapy;
- Referral or use of out-of-network providers for non-emergency services, unless the covered person understands and consents to the use of an out-of-network provider under their out-of-network benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

6.2: Prior Authorization Review Procedures

The Pre-Certification review procedures are as follows:

- The Participant must advise the Physician of the Plan's Pre-Certification review program;
- The Physician or the Participant must request approval from the Claims Administrator **prior to** any non-experimental organ transplant, which includes bone marrow, cornea, kidney, heart, heart-lung, liver and or pancreas;

6.3: Failure to Follow Prior Authorization Review Procedures

If a Participant fails to follow the Pre-Certification review procedures of Section 5.2, no benefit will be payable under this Plan for any benefit for which a Pre-Certification was required, but failed to be obtained.

6.4: Denial by Claims Administrator

If approval of any services is denied by the Claims Administrator, the Participant may file a written appeal with the Claims Administrator within (60) sixty days of the denial. An appeal should include any supporting facts that would clarify or strengthen the Participant's request for Prior Authorization.

6.5: Pre-Certification

A Pre-Certification may be obtained to determine if the procedure is a Medically Necessary procedure and what benefits are available.

If a Participant is being case managed and alternative treatment options are recommended that are not usually covered by the Plan, the Plan has the right to authorize coverage for these situations. Alternate cost effective forms of care, treatment or treatment facilities may be recommended as part of the case management program. Payment for these expenses which are recommended by a Case Manager may be covered at a participating care rate by the Plan Sponsor, with pre-approval by the Plan Sponsor.

ARTICLE VII: COORDINATION OF BENEFITS

7.1: Purpose

The purpose of this Article is to coordinate the payment of benefits between this Plan and one (1) or more other Health Plans. By coordinating the payment of benefits of those Participants having coverage with one (1) or more Health Plans, maximum benefits for services may be provided by paying up to, but not more than 100% of the Covered Medical Expenses. In some cases payment will be less than 100%.

7.2: Primary and Secondary Plans

If other insurance coverage is indicated via a separate insurance or medical plan, that group program is called the primary plan. This Plan which determines its benefit payment after the other plan(s) is called the secondary plan. Secondary plan benefit payments are limited so that the total amount from all group plans will not be more than the actual amount of covered expenses incurred by the Participant.

This Plan will coordinate benefits on a non-duplication of benefits basis. If this Plan is paying secondary benefits, the benefit would be calculated as if primary payment was to be made, and the other carrier's benefit is then deducted from this calculation. If a balance is left, then the Plan will pay this amount as a secondary payment. If no balance is left, no payment is made.

Example: The charge is $100 and is an 80% benefit payment under this Plan.

1.	Charge	=	$100
	This Plan's calculated payment at 80%	=	$ 80
	Primary payor's payment	=	- 80
	This Plan will pay		$ 0
2.	Charge	=	$100
	This Plan's calculated payment at 80%	=	$ 80
	Primary payor's payment	=	- 75
	This Plan will pay		$ 5

7.3: Eligible Plans

Health Plans providing benefits or services for treatment and coordinated with this Plan include:

A. Any group, blanket or franchise insurance plan whether insured or uninsured;
B. Any Hospital or medical service plan or any group practice or prepayment plan;
C. Any union welfare or labor management trusted insurance plan;
D. Any government insurance plan or coverage required by law subject to the provisions of Section 4.5 of this Plan and provided further that medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act ("Medicaid") will not be taken into account; or
E. Any automobile coverage covering a Participant including, but not limited to, personal injury protection, no fault or med-pay coverage.

7.4: Payment of Benefits

If this Plan is primary, it will pay benefits as outlined. If this Plan is secondary, benefits will be calculated per the Plan's provisions after receipt of the primary payor's explanation of benefits.

7.5: Right to Receive and Release Necessary Information

For the purpose of determining the applicability of and implementing the terms of this section or any provision of similar purpose of any other Health Plan, this Plan may, without the consent of or notice to any person claiming benefits under this Plan, release to or obtain from any other organization or person any information with respect to any person which this Plan deems to be necessary for these purposes. Any person claiming benefits under this Plan will furnish to this Plan any information necessary to implement this section.

ARTICLE VIII: ADMINISTRATION

8.1: Student Medical Plan Committee

Those persons who are charged with the oversight of all aspects of the Student Medical Plan.

8.2: Committee Structure

The Student Medical Plan Committee shall consist of representatives from the Office of General Counsel, Office of Risk Management, Office of Student Affairs and the Office of the Provost.

8.3: Committee Powers and Duties

The Student Medical Plan Committee shall have such powers and duties as may be necessary to discharge its obligations hereunder, as designated by the Plan Sponsor, including, but not by way of limitation, the following:

- To construe and interpret the Plan in its absolute discretion and to determine all questions arising in the administration, interpretation and application of the Plan. Any such actions, determinations or decisions of the Student Medical Plan Committee shall presumptively be conclusive and binding on all persons;
- To receive from the Plan Administrator and Claims Administrator such information as may be necessary for determining proper management of the Plan;
- To appoint or employ individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal counsel.

8.4: Committee Procedures

The Student Medical Plan Committee may act at a meeting or in writing without a meeting. The Student Medical Plan Committee may adopt such by-laws and regulations as it deems desirable for the conduct of its affairs. All decisions of the Student Medical Committee shall be made by a consensus, including actions in writing taken without a meeting.

The Student Medical Plan Committee shall exercise such authority and responsibility as it deems appropriate in order to comply with all applicable laws and governmental regulations issued thereunder relating to records of Participants.

8.5: Committee Rules and Decisions

The Student Medical Plan Committee may adopt such rules as it deems necessary, desirable, or appropriate. All rules and decisions of the Student Medical Plan Committee shall be uniformly and consistently applied to all Participants in similar circumstances under similar conditions and facts. In making a determination or calculation, the Student Medical Plan Committee shall be entitled to rely upon information furnished by the Plan Administrator, Participant, any Provider or any professional retained by any of the aforementioned persons or the Student Medical Plan Committee itself, including, but not limited to attorneys, accountants, CPAs, auditors and other professions.

8.6: Indemnification of the Committee

The Student Medical Plan Committee and the individual members thereof shall be indemnified by the Plan Sponsor against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

8.7: Plan Administrator

Those persons who are empowered by the Student Medical Plan Committee to administer and manage the proper execution of the Student Medical Plan.

8.8: Plan Administrator's Powers and Duties

The Plan Administrator shall have such powers and duties as may be necessary to discharge its obligations hereunder, as designated by the Student Medical Committee, including, but not by way of limitation, the following:

- To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments and disbursements for expenses from the Claims Administrator;
- To receive from the Claims Administrator, various Providers and Participants such information as may be

necessary for the proper administration of the Plan.

- To prescribe procedures to be followed by Participants filing applications or claims for benefits;
- To make determinations, as necessary, related to disputes of eligibility and benefit interpretation;
- To disseminate information relative to eligibility, benefit design and plan changes to the Claims Administrator, Participants and any other stakeholder in order to facilitate the operation of the Plan;
- To present to the Student Medical Plan Committee relevant information with regards to enrollment, fees, medical and prescription expenditures, health care regulations and any other ad hoc reports or information as requested or deemed necessary.

8.9: Indemnification of the Plan Administrator

The Plan Administrator and the individual members thereof shall be indemnified by the Plan Sponsor against any and all liabilities arising by reason of any act or failure to act made in good faith pursuant to the provisions of the Plan, including expenses reasonably incurred in the defense of any claim relating thereto.

8.10: Claims Administrator

The Claims Administrator shall be responsible for the processing of claims, reviewing benefits for purposes of prior authorization, providing certain financial services, providing reports and making initial benefit determinations subject to the Plan and direction of the Student Medical Plan Committee. It does not fund or insure claim payments or bear any financial risk with regard to Plan expenses.

8.11: Authorization of Claims Processing

The Student Medical Plan Committee hereby authorizes the Claims Administrator to process claims in accordance with the provisions of the Plan.

ARTICLE IX: CLAIMS PROCESSING

9.1: Claims Processing Procedures

This section describes what to do in order to receive benefits under this Plan. The Participant should contact the Claims Administrator if they have any questions regarding the claims processing procedures.

A. Claims Submission Procedure

The Participant must send all itemized bills as soon as possible after treatment is rendered to the Participant or their Dependent to Aetna Student Health. The Participant**'s** name, identification number and Case Western Reserve University should be written clearly and attached to the medical bills. All information should be mailed to:

Aetna Student Health
P.O**.** Box 981106
El Pasco, TX 79998

- Aetna Customer Service Representatives are available at (877) 850-6038 from 8:30 a.m. to 5:30 p.m. Monday through Friday, for any questions.
- Bills must be submitted within 15 months from the date of treatment.
  Payment of covered medical expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
- If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.

In all cases, expenses must be filed within 15 months of treatment to be considered for payment under this Plan.

B. Appeal of Adverse Benefit Determination

Review Procedures: If the Participant believes an adverse benefit determination occurred, including a belief that a denial of a claims was improper, the following process should be adhered to:

1. Within 60 days of receipt of the adverse benefit determination or denial of the claim, the Participant may request, in writing, that the Claims Administrator conduct a review of the determination. The Claims Administrator will review the benefit determination and inform the Participant whether or not an error was made.
2. If the Claimant is not satisfied with the above review, a written request for a second review may be submitted to the Claims Administrator within 60 days of the first review. The request should state, in clear and concise terms the reason for disagreement the adverse benefit determination or denial of the claim. When the written request is received, the benefit determination will be reviewed again and the results of the review furnished in writing to the participant within 60 days in most cases, but no longer than 120 days.
3. All requests for review of adverse benefit determination, including denied claims, should include a copy of the initial denial letter and any other pertinent information. All information should be sent to:

   Aetna Student Health
   P.O. Box 981106
   El Pasco, TX 79998

If the Participant is not satisfied with the decision after two claim reviews noted above an appeal may be made to the Plan Administrator. The Plan Administrator will conduct its review without difference to the initial benefit determination and taking into account all comments, documents, records and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

C. Authorized Representative

A Participant is permitted to designate an authorized representative to act on their behalf with respect to a benefit claim or appeal of an adverse benefit determination. Designation of an authorized representative must be in writing. The Plan will permit a health care professional with knowledge of the Participant's condition (such as a treating Physician) to act as the authorized representative of the Participant.

This designation of an authorized representative should be sent to the Claims Administrator as noted to the above provided address.

D. Amendment of Claims Procedures

The claims and payment procedures may be amended at any time, in whole or in part, in accordance with the amendment procedures set forth in the Plan.

9.2: Appeals

Expedited Reviews
Expedited Review of an appeal may be initiated orally, in writing, or by other reasonable means available to you or your Provider. Expedited Review is available only if the medical care for which coverage is being denied has not yet been rendered. We will complete expedited review of an appeal as soon as possible given the medical exigencies but no later than seventy-two hours (72 hours) after Case Western University's receipt of the request and will communicate its decision by telephone to your attending Physician or the ordering Provider. We will also provide written notice of our determination to you, your attending Physician or ordering Provider, and the facility rendering the service.

You may request an expedited review for:

- Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent cares determinations:
    1. Could seriously jeopardize your life or health or your ability to regain maximum function, or,

    2. In the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

- Except as provided above, a claim involving urgent care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.
- Any claim that a Physician with knowledge of your medical condition determines is a claim involving urgent care.

External Reviews
After exhaustion of all appeal rights stated above, a Covered Person may also request a final independent external review of any Adverse Benefit Determination involving a question of Medical Necessity, or other issue requiring medical expertise for resolution.

To assert this right to independent external medical review, the Covered Person must request such review in writing within one hundred twenty (120) days after a decision is made upon the second level benefit determination above.

If an independent external review is requested, the Claims Administrator will forward the entire record on appeal, within ten (10) days, to an independent external review organization (IRO) selected randomly. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will issue a final decision within forty-five (45) days after receipt of all necessary information.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

If your claim for a benefit was denied in whole or in part, you may appeal the decision through the following procedure:

- Within 60 days of receipt of the denial letter or explanation of benefits (EOB) form from HealthSmart, you may request, in writing or verbally, that Case Western Reserve University conducts a review of the processed claim. Case Western will review the processed claim and inform you whether or not an error was made. Any errors will be corrected promptly.
- If you are not satisfied with the result of this review, you may request a second review. This request must be in writing and must be submitted to Case Western Reserve University within 60 days of the date of the completion of the first review. The request should state in clear and concise terms why you disagree with the way the claim was processed.
- In most cases, the decision on the second review will be furnished in writing within 60 days but in no case more than 120 days.

ARTICLE X: HIPAA PRIVACY

10.1: HIPAA Privacy

Use and Disclosure of Protected Health Information (PHI)

A federal law, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), requires that health plans protect the confidentiality of a Participants private health information (PHI).

The Plan may, without the consent or authorization of the individual, use and disclose PHI for health care treatment, health care payment, and health care operations, and for such other uses or disclosures to the full extent permitted by regulations promulgated by the Secretary of Health and Human Services to implement HIPAA, subject to more stringent state privacy laws which do not conflict with HIPAA (if any).

This Plan, and the Plan Sponsor, will not use or further disclose PHI without authorization except as noted in the privacy notice as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. The Plan may disclose PHI to such other persons and for the other purposes when authorized by the Participant on a form and in a manner provided for in regulations promulgated by the Secretary of Health and Human Services to implement HIPAA. By law, the Plan has required all of its business associates to also observe HIPAA privacy rules. In particular, The Plan will not, without authorization, use or disclose protected health information in connection with any other decisions that pertain to a Student's and/or their Dependent's status and/or affiliation with the University or any of its programs.

Under HIPAA, a Participant has certain rights with respect to their protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. A Participant also has the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if the Participant believes that their rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of a Participants rights under HIPAA privacy rules. A copy of the notice is provided to Participants and an additional copy of the notice can be obtained from the University Health Service Department at Case Western Reserve University, 10900 Euclid Avenue, Cleveland, Ohio 44106-4901, (216) 368-3050.

Disclosing information for “payment,” as referred to above, includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits which relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
2. Adjudication of health benefit claims (including appeals and other payment disputes);
3. Subrogation of health benefit claims;
4. Establishing Student Contributions;
5. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
6. Billing, collection activities and related health care data processing;
7. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
8. Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
9. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
10. Utilization review, including Prior Authorization, concurrent review and retrospective review;
11. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and Reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting Providers and Participants with information about treatment alternatives and related functions;
3. Rating Provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for

reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvements of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to the implementation of and compliance with
8. Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
9. Resolution of internal grievances; and
10. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

With Respect to PHI, the Plan Sponsor Agrees to Certain Conditions:

1. Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. Not use or disclose PHI in connection with any other decisions that pertain to the student's and/or their dependent's status and/or affiliation with the University or any of its programs
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to an individual in accordance with HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI as appropriate and in accordance with HIPAA;
8. Make available the information required to provide an accounting of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

Adequate separation between the Plan and the Plan Sponsor must be maintained

In accordance with HIPAA, only the following classes of individuals may be given access to PHI:

1. The benefits manager(s) and the staff designated by the benefits manager;
2. Claims Administrator and the staff designated by the Claims Administrator;
3. Plan Administrator and the staff designated by the Plan Administrator;
4. Student Medial Plan Committee and its designees; and
5. Utilization Review Service and its designees.

Limitations of PHI Access and Disclosure

The persons described in Paragraph D of this Section may only have access to and use and disclose PHI for plan administration functions which the Plan Sponsor performs for the Plan.

Noncompliance Issues

If the persons described in Paragraph D of this Section do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

10.2: HIPAA Security

It is the intent of the plan to comply with the requirements of 45 C.F.R.§ 164.314 (b) (1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor obligations with respect to the security of Electronic Protected Health Information. The obligations set forth below are effective April 21, 2006.

A. Definitions

1. Electronic Protected Health Information. The term "Electronic Protected Health Information" or "Electronic PHI" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.
2. Plan Documents. The term "Plan Documents" means the Amended and Restated Medical Care Plan for Students and their Dependents governing documents and instruments (*i.e.*, the documents under which the Amended and Restated Medical Care Plan for Students and their Dependents was established and is maintained), including but not limited to the Case Western Reserve University Amended and Restated Medical Care Plan for Students and their Dependents Summary Plan Description and Plan Document.
3. Plan Sponsor. The Plan Sponsor is Case Western Reserve University.
4. Security Incidents. The term "Security Incidents" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

B. Plan Sponsor Obligations.

Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

1. Plan sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that Plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;
2. Plan sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
3. Plan sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and
4. Plan sponsor shall report to the Plan any Security Incidents of which it becomes aware.

ARTICLE XI: MISCELLANEOUS

11.1: No Rights to Assets of Plan Sponsor or Plan Assets

No Participant shall have any right to, or interest in, any assets of the Plan Sponsor, or if applicable, any assets of the Plan upon termination of his Student status or otherwise. All payments of benefits as provided for in the Plan shall be made solely out of the assets of the Plan and none of the fiduciaries shall be liable, therefore, in any manner.

11.2: Non-Alienation of Benefits

Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

11.3: Right of Reimbursement

This section applies when the Participant has recovered damages, by verdict, judgment, settlement or otherwise, for an Injury or Sickness (including an occupational Injury or Sickness) caused by a third party. If the Participant has made, or in the future may make, such a recovery, including a recovery under a first-party automobile coverage, the Plan will not cover either the reasonable value of the services to treat such an Injury or Sickness or the treatment of such an Injury or Sickness.

However, if the Plan pays for or provides benefits for such an Injury or Sickness, the Participant shall promptly, when the recovery is received, reimburse the Plan from the monies recovered under the judgment, settlement or otherwise when the recovery is received for the amount the Plan has been fully reimbursed for benefits it paid for or provided benefits for said Injury or Sickness. Reimbursement shall be made regardless of whether the Participant has been made whole or fully reimbursed by the third party for his damages and regardless of any classification of such recovered proceeds as medical expenses or otherwise.

The Plan has a lien in the proceeds of any such recovery. The Participant shall sign and deliver, at the Plan's request, any documents needed to protect this lien. This lien shall remain in effect until the Plan is repaid in full.

The Participant shall cooperate with the Plan, including signing and delivering any documents the Plan reasonably requests to protect its rights of reimbursement, providing any relevant information, and taking such actions as the Plan may otherwise request in order to recover the full amount of benefits provided. The Participant shall not reduce the Plan's right of reimbursement.
These rights provide the Plan with a priority over any funds paid by a third party to a Participant relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney’s fees, or other costs and expenses. The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing.

11.4: Subrogation

This section applies when another party is, or may be considered, liable for a Participant's Injury or Sickness (including an Occupational Injury or Sickness) and the Plan has provided or paid for benefits.

To the extent of the benefits provided by the Plan, the Plan is subrogated to all of the Participant's rights against any party (including any first party automobile coverage) or for the payment for the medical treatment of such Injury or Sickness. The Plan may assert this right independently of the Participant. The Plan shall be subrogated to such rights of the Participant regardless of whether the Participant has been made whole or fully reimbursed by the third party for his damages and regardless of any classification of such recovered proceeds as medical expenses.

The Participant is obligated to cooperate with the Plan in order to protect the Plan's subrogation rights. Such cooperation shall include providing the Plan with any relevant information, signing and delivering such documents as the Plan reasonably requests to secure its subrogation claim, and obtaining the Plan's consent before releasing any party from liability for payment of medical expenses. The Participant assigns to the Plan the Participant's rights and benefits under any insurance coverage, whether liability or no-fault, to the extent of the Plan's subrogation claims under this section.

If the Participant enters into litigation or settlement negotiations regarding the obligations of other parties, the Participant must not prejudice, in any way, the recovery rights of the Plan under this section.

The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Participant in matters related to subrogation shall be borne solely by the Participant.

11.5: Medicaid Assignment of Rights and Reimbursement

Payment of benefits with respect to a Participant under the Plan will be made in accordance with any assignment of rights made by or on behalf of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of the Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993). Provided further that to the extent that payment has been made under such state plan in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance, payment of benefits under the Plan will be made in accordance with any state law.

ARTICLE XII: AMENDMENTS AND ACTION BY THE PLAN SPONSOR

12.1: Amendments

The Plan Sponsor reserves the right at any time to make any amendment or amendments, to the Plan at its sole discretion by a signed written document. The Plan Sponsor will inform all Participants of any amendment modifying the substantive terms of the Plan not later than two hundred ten (210) days after the close of the Plan Year in which the amendment was adopted; provided however, that if the amendment is a material reduction in covered services or benefits, the Participants will be notified not later than sixty (60) days after the date of adoption of the amendment.

12.2: Action by the Plan Sponsor

Any action by the Plan Sponsor acting by its Board of Trustees under this Plan may be by any person or persons duly authorized by resolution of said Board of Trustees to take such action.

ARTICLE XIII: SUCCESSOR PLAN SPONSOR AND MERGER OR CONSOLIDATION OF PLANS

13.1: Successor to the Plan Sponsor

In the event of the dissolution, merger, consolidation or reorganization of the Plan Sponsor, provision may be made by which the Plan will be continued by the successor, and, in that event, such successor shall be substituted for the Plan Sponsor under the Plan. The substitution of the successor shall constitute an assumption of Plan liabilities by the successor and the successor shall have all the powers, duties and responsibilities of the Plan Sponsor under the Plan.

ARTICLE XIV: PLAN TERMINATION

14.1: Right to Terminate

The Plan Sponsor, by action of its Board of Trustees at a meeting duly called and held or by written agreement, may terminate the Plan in whole or in part at any time in its, sole discretion. If Case Western Reserve University terminates and does not replace this Plan, students then receiving or entitles to receive benefits for a covered Sickness or Injury will continue to be covered for that Disability for up to 52 weeks following the date of termination or in accordance with the time period stated under the Student Medical Plan, whichever is less.

14.2: Liquidation of the Plan Assets

Upon termination of the Plan, the Plan assets (if any) shall continue until the Plan Sponsor has paid all proper pending claims for benefits outstanding as of the date of termination and the remaining balance shall be liquidated and paid over to the Plan Sponsor's corporate assets, unless otherwise determined by the appropriate body of the Plan Sponsor.

ARTICLE XV: DEFINITIONS

Where the following defined terms are used throughout this document, they are capitalized for ease of reference.

Accident
A sudden, unexpected and unforeseen, identifiable event producing at the time objective symptoms of an Injury. The Accident must occur while the Participant is covered by this Plan.

Alcoholism Treatment Facility

An institution that mainly provides a program for diagnosis, evaluation and effective treatment of alcoholism. It must make charges and meet applicable licensing standards. It prepares and maintains a written treatment plan on each patient based on medical, psychological and social needs, which plan must be supervised by a Physician. The institution must provide the following twenty-four (24) hours a day:

a. Detoxification services;
b. Infirmary level medical services required for the treatment of any Sickness or Injury manifested during the treatment period, whether or not related to the alcoholism and arrangement of Hospital level medical services, if needed;
c. Supervision by a staff of Physicians; and
d. Skilled nursing care by licensed nurses who are supervised by a Registered Graduate Nurse.

Alcoholism and Drug Addiction Treatment

A chronic and habitual use of alcoholic beverages to the extent that the user no longer can control the use of alcohol or endangers the user's health, safety, or welfare of that of others; the use of a drug of abuse to the extent that the user becomes physically or psychologically dependent on the drug or endangers the user's health, safety, or welfare or that of others.

Ambulatory Surgical Facility

A specialized facility which is established, equipped, operated, and staffed primarily for the purpose of performing Surgery and which fully meets one (1) of the following two (2) tests:

a. It is licensed as an Ambulatory Surgical Facility by the regulatory authority having responsibility for the licensing of such facilities under the laws of the jurisdiction in which it is located; or
b. Where licensing is not required, it meets all of the following requirements:
    i. It is operated under the supervision of a Physician who is devoted full time to supervision and permits Surgery to be performed only by a duly qualified Physician who, at the time the Surgery is performed, is privileged to perform the Surgery in at least one (1) Hospital in the area;
    ii. It requires in all cases, except those requiring only local infiltration Anesthesia, that a licensed anesthesiologist administer the Anesthesia or supervise an anesthetist who is administering the Anesthesia and that the anesthesiologist or anesthetist remain present throughout the Surgery;
    iii. It provides at least one (1) operating room and at least one (1) post-Anesthesia recovery room;
    iv. It is equipped to perform diagnostic X-ray and laboratory examinations or has an arrangement to obtain these services;
c. It has trained personnel and necessary equipment to handle emergency situations;
d. It has immediate access to a blood bank or blood supplies;
e. It provides the full-time services of one (1) or more Registered Graduate Nurses for patient care in the operating room and in the post-Anesthesia recovery room; and
f. It maintains an adequate medical record for each patient, the record contains an admitting diagnosis including, for all patients except those undergoing a procedure under local Anesthesia, a preoperative examination report, medical history and laboratory test and/or X-rays, an operative report and a discharge summary.

Ancillary Charge

A charge for services and supplies required for the care and treatment of Sickness or Injury, other than Room and Board Charges, fees for professional services, or charges for nursing care or personal items such as television, telephone, laundry, barber or beauty services, etc.

Anesthesia

Local - the condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.
General - the condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Annual Plan Year Maximum Benefit:
The period of time from anniversary date to anniversary date except in the first year when it is the period of time from the effective date to the first anniversary date.

Benefit Year
The Benefit Year is determined by program specification. Professional Students and Dependents begin July 1 and ends June 30. All other Students and Dependents begin August 1 and end July 31.

Birthing Center
A specialized facility which is primarily a place for delivery of a Child following a normal uncomplicated Pregnancy and which fully meets one (1) of the following two (2) tests:

a. It is licensed by the regulatory authority having responsibility for the licensing of such facilities under the laws of the jurisdiction in which it is located; or
b. If there is no state licensing requirement for such facilities, it meets all of the following requirements:
c. It is operated and equipped in accordance with any applicable state law;
d. It is equipped to perform routine diagnostic and laboratory examinations such as hematocrit and urinalysis for glucose, protein, bacteria and specific gravity;
e. It has available to handle foreseeable emergencies trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders;
f. It is operated under the full-time supervision of a Physician or Registered Graduate Nurse;
g. It maintains a written agreement with at least one (1) Hospital in the area for immediate acceptance of patients who develop complications; and
h. It maintains an adequate medical record for each patient, containing prenatal history, prenatal examination, any laboratory or diagnostic tests and a postpartum summary.

Calendar Year
January 1st through December 31st.

Certified Registered Nurse Anesthetist
A Certified Registered Nurse (CRNA) is a registered nurse who is licensed or certified to administer general or spinal anesthesia by the state of practice.
Cover charges made by a Certified Registered Nurse Anesthetist (CRNA) who is:

a. Licensed or certified to administer general or spinal anesthesia by the state of practice
b. Practicing within the scope of the license or certification, and
c. Providing a service covered by the policy.

Child
The term "Child" for purposes of this Plan, shall include any Child of a participating Student who falls within one (1) of the following categories:

1. Any step-Child;
2. Any legally adopted Child including any Child Placed for Adoption while the adoption proceedings are pending;
3. Any foster Child;
4. Any natural Child;
5. Any Child covered under a Qualified Medical Child Support Order issued to a participating Student or his Spouse; and
6. A Child of a Domestic Partner of a Student when the Student and Domestic Partner have executed an affidavit of Domestic Partnership.

Claims Administrator
The Claims Administrator shall be responsible for the processing of claims, reviewing benefits for purposes of prior authorization, providing certain financial services, providing reports and making initial benefit determinations subject to the Plan and direction of the Student Medical Plan Committee. It does not fund or insure claim payments or bear any financial risk with regard to Plan expenses.

Congenital Anomaly
An error of morphogenesis (structural) which is either established at conception or acquired during intrauterine life.

Copayment or copay
The portion of a Provider's Usual, Customary and Reasonable Charges Fees and Expenses that is the Participant's financial responsibility, pursuant to Article III.

Cosmetic Surgery
Surgery that is not the result of an Injury, Sickness or congenital anomaly and is not Medically Necessary, but is for the sake of appearance.

Covered Medical Expenses
The Usual, Customary and Reasonable Charges Fees and Expenses incurred by or on behalf of a Participant for those covered expenses set forth in Article IV, but only if such Usual, Customary and Reasonable Charges, Fees and Expenses are incurred after the Participant commences participation in the Plan and only to the extent that the services or supplies provided to the Participant are recommended by a Physician for Medically Necessary care of any non-Occupational Sickness or Injury.

Covered Service
An item, treatment, procedure, admission or medication that is Medically Necessary and appropriate for the diagnosis as set forth in the Plan as determined by the Plan Administrator.

Custodial Care
Services and supplies that:

a. Are furnished mainly to train or assist the patient in personal hygiene and other activities of daily living, rather than to provide therapeutic treatment; and
b. Can safely and adequately be provided by persons without the technical skills of a Provider.
c. Such care is custodial regardless of who recommends, provides and directs it, where it is given and whether or not the patient can be or is being trained to provide self-care.

Dependent
This term includes:

a. The Spouse or Domestic Partner of a Student; or
b. Any Child of a Student who is under the age of 26 and meets the criteria for dependent status.
c. Disability- the condition of being disabled is the inability to pursue an occupation because of physical or mental impairment.

Domestic Partner
Two (2) individuals of the same or opposite sex who:

a. Are both eighteen (18) years of age or older and have the capacity to enter into a contract; and
b. Are involved in an exclusive, long-term and committed relationship; and
c. Have resided together in a common household continuously for at least six (6) consecutive months; and
d. Who intend to reside together indefinitely; and
e. Who are not related by blood to a degree of closeness which would prohibit legal marriage in a State in which the legal partners reside; and
f. Have agreed to be jointly responsible for each other's welfare, financial obligations, and basic living expenses, including food, shelter, and healthcare expenses; and
g. Who are not married, who are not involved in any other domestic partnership, and who have not been involved in any other domestic partnership or marriage for the last twelve (12) months, unless that domestic partnership or marriage ended because of death.

Durable Medical Equipment
Equipment which is:

a. Able to withstand repeated use;
b. Primarily and customarily used to serve a medical purpose; and

c. Not generally useful to a person in the absence of Sickness or Injury.

Enrollment Date
With respect to a Participant, the date of enrollment in the Plan, or if earlier, the first day of the waiting period for such enrollment.

Enrollment Period
The period elected by the Plan Administrator during which an eligible Student may elect to participate in the Plan, or a Participating Student may elect to revoke a prior election to participate in the Plan, choose to be covered by another Plan or to add or eliminate coverage of Dependents.

Experimental/Investigative
The use of any treatment, procedure, facility, equipment, drugs, devices or supplies not yet recognized by the Plan as acceptable medical practice as determined within the sole discretion of the Plan Administrator. This term will also apply if the services or supplies require Federal or other governmental agency approval and that approval was not granted at the time the services were received.

For purposes of the Plan, any treatment, procedure, facility, equipment, drugs, devices or supplies shall be experimental/investigative if: (a) not widely accepted throughout the Participant's geographic area by Physician Providers practicing in such geographic area as being safe, effective and appropriate for the Injury or Sickness; or (b) used for research or investigational use; or (c) conducted as part of a research protocol; or (d) not proved by statistically significant randomized clinical trials to establish increased survival or improvement in the quality of life over other conventional therapies; or (e) not approved by the Food and Drug Administration or other applicable governmental agency for general use at the time received if such approval was required to lawfully provide the drug or device; or (f) approved for a specific medical condition by the Food and Drug Administration or other applicable governmental agency but applied to another Sickness, Injury or conditions for which approval was required and not obtained at the time the drug, device, medical procedure or treatment was provided.

Extended Care Facility
A lawfully operated institution or that part of such an institution which assists patients in reaching the degree of body functioning necessary to permit self-care in essential daily living activities and:

a. Is primarily engaged in providing, under the supervision of a Physician and on a full-time Inpatient basis, care and treatment of five (5) or more persons convalescing from Injury or Sickness;
b. Provides twenty-four (24) hour-a-day professional nursing services supervised by a Registered Graduate Nurse regularly on duty within the premises;
c. Maintains a daily clinical record of each patient; and
d. Is not, except incidentally, a place for the aged, the treatment of drug or alcohol dependency, nor a place for custodial or educational care.

Family and Medical Leave Act
The Family and Medical Leave Act (FMLA) of 1993, as it may be amended from time to time, together with its related rules and regulations. References to any Section of the Family and Medical Leave Act shall include any successor provision(s) thereto.

Family Unit
Participant's immediate family consisting of spouse, domestic partner, natural child, adopted child, child of a domestic partner, and/or step-child.

Full-Time Student
"Full –time Student" shall mean an individual who is enrolled at, and attends the University of Special Programs during each of five (5) calendar months during the Plan Year; provided, however, (1) the individual is carrying the required number of course hours to be participating in the full-time course of study at the University or Special Programs, or (2) is on a medically necessary leave of absence from such University or Special Programs, as certified by a physician, if such leave of absence extends no longer than one (1) year from the first day of medically necessary leave of absence , as provided in the federal Michele's Law, Pub L 110-381. The required five (5) calendar months need not be consecutive. Attendance of school exclusively at night does not constitute a full-time course of study.

Full-Time Student is defined by the school the student attends and varies according to quarter hours or semester hours, length of terms, and other school specific standards. When the Claims Administrator requests student status verification, enrollment and full- time status will be verified against the school's standards.

Health Plan or Medical Care Plan
A benefit plan that provides for Medical Care to Students or their Dependents through insurance, reimbursement or otherwise.

Health Insurance Coverage
Benefits consisting of Medical Care provided directly, through insurance or reimbursement or otherwise, and including items and services paid for as Medical Care under any Hospital or medical service policy or certificate, Hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer.

HIPAA
The Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, August 21, 1996, as amended from time to time.

Home Health Care
The care and treatment of Sickness or Injury by a Home Health Care Agency.

Home Health Care Agency
An agency or organization that specializes in providing skilled nursing services and other therapeutic services and is providing Medical Care and treatment in the home. Such an agency or organization must meet all of the following requirements:

a. It is primarily engaged in providing skilled nursing services and other therapeutic services and is licensed by the Community Health Accreditation Program (CHAP) to provide such services;
b. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) Registered Graduate Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Graduate Nurse;
c. It has a full-time administrator; and
d. It maintains a complete medical record on each patient.

Hospice Care Agency
An agency or organization that offers a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for persons suffering from a condition that has a terminal prognosis. Such organization must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Graduate Nurse, and it must maintain centralized clinical records on all patients. It must meet the standards of the National Hospice Organization (NHO) and any applicable state licensing requirements.

Hospital
An institution which:

a. Provides Medical Care and treatment of Injured persons and/or persons with a Sickness on an Inpatient basis;
b. Does so at the patient's expense;
c. Maintains facilities for surgical and medical diagnosis and treatment by or under the supervision of a staff of Physicians;
d. Provides twenty-four (24) hour-a-day nursing service by or under the supervision of a Registered Graduate Nurse;
e. Provides lab and X-ray services twenty-four (24) hours a day;
f. Operates continuously with organized facilities for Surgery; and
g. Is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Health Care Organizations.

Injury
Means bodily damage (1) caused directly and independently of all other causes by an Accident and (2) which results in loss covered by the Plan.

Inpatient
Anyone treated as a registered bed patient in a Hospital or other institutional Provider.

Intensive Care Unit
A separate and distinct part of a Hospital reserved for critically and seriously ill patients requiring highly skilled nursing care and close, frequent, if not constant, audiovisual observation and which provides for such patients the following:

a. Room and Board;
b. Nursing care by nurses whose duties are confined to the care of patients in such unit; and
c. Specialized equipment and supplies immediately available on a standby basis segregated from the rest of the Hospital's facilities.

Licensed Practical Nurse
A person who has undergone training and obtained a license (as from a state) to provide routine care for the sick, also called LPN.

Live Event
The occurrence of one or more of the following:

a. Change in Legal Marital Status. Events that change a Student's legal marital status, including the following; marriage, death of Spouse, divorce, legal separation and annulment.
b. Number of Dependents. Events that change a Student's number of Dependents, including the following: birth, death, adoption and Placement for Adoption.
c. Change in Employment Status. Any of the following events that change the employment status of the Student, his Spouse, or Dependent; a termination of commencement of employment, a strike or lockout, a commencement of return from an unpaid leave of absence, change in worksite of change in employment status with the consequence of the individual becoming (or ceasing to be) eligible under the employer's group health plan.
d. Dependent Satisfies or Ceases to Satisfy Eligibility Requirement. Events that cause a Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, student status or any similar circumstance.
e. Residence. A change in the place of residence of the Student, Spouse or Dependent.
f. Open Enrollment. The Student's plan or Spouse's plan holds an open enrollment.

Medical Care
Medical Care includes treatment and the Usual, Customary, and Reasonable Charges, Fees, and Expenses for: (a) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (b) Usual Customary, and Reasonable Charges, Fees and Expenses for transportation primarily for and essential to the Medical Care referred to in subparagraph (a) of this Section; and (c) amounts paid for insurance covering Medical Care referred to in subparagraph (a) and (b) of this Section.

Medical Emergency
The sudden and unexpected onset of a Sickness or Injury with severe symptoms requiring Medical (as opposed to surgical) Care. To be a Medical Emergency, the Sickness or Injury, as finally diagnosed or as indicated by its symptoms, must be one which would normally require immediate Medical Care, such as, but not limited to, acute appendicitis, asthmatic attack, kidney stone attack, stroke, poisoning (including overdoses) or convulsions.

In order to determine whether a Medical Emergency exists, the following requirements will be applied:

a. Severe symptoms must occur and the symptoms must be sufficiently severe to cause a person to seek immediate medical aid regardless of the hour of day or night;
b. Severe symptoms must occur suddenly and unexpectedly. A chronic condition in which moderately acute symptoms have existed over a period of time would not qualify for Medical Emergency consideration. However, if symptoms suddenly become severe enough to require immediate medical aid, it may at that point, so qualify;
c. Immediate care is secured - a Medical Emergency would not be considered to exist if Medical Care is not secured immediately after the appearance of symptoms. A telephone call to a Physician does not meet this

requirement if deferred beyond forty-eight (48) hours after the appearance of symptoms; and

d. The Sickness or Injury as finally diagnosed or as indicated by its symptoms and the degree of severity of the Sickness or Injury is such that immediate Medical Care would normally be required.

Medically Necessary Care (or Medical Necessity or Medically Necessary)

Medically Necessary Care and treatment that is recommended or approved by a Physician or Other Provider, is consistent with the patient's condition, symptoms, diagnosis or accepted standards of good medical or dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or Provider of medical or dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician or Other Provider recommends or approves certain care does not mean that it is Medically Necessary. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare

The program of Medical Care benefits provided under Title XVIII of the Social Security Act of 1965, as amended. Part A means Medicare's Hospital Plan and Part B means Medicare's Voluntary Hospital Supplemental Medical Plan.

Mental Disorder Treatment Facility

An agency or organization that provides a program for diagnosis, evaluation and effective treatment of Mental/Nervous Disorders. It is not a school, custodial, recreational or training institution. It provides infirmary-level medical services required for the treatment of any Sickness or Injury manifested during the treatment period, whether or not related to the Mental/Nervous Disorder and arranges Hospital services if needed. It has at least one (1) Psychiatrist present during the entire treatment day. It provides the services of a psychiatric social worker and a psychiatric nurse twenty-four (24) hours a day. It prepares and maintains a written treatment plan for each patient which must be supervised by a Psychiatrist. The treatment plan is based on a diagnostic assessment of the patient's medical, psychological and social needs. Such agency or organization must meet all applicable licensing requirements for facilities providing such services.

Mental/Nervous Disorders

Neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Mental Health Care or Treatment

Services directed to the effective treatment of the emotional and mental well-being of the individual, including electroshock therapy administered by a Physician and Anesthesia for the same. Marital, family and financial counseling are not Covered Medical Expenses.

Miscellaneous Hospital Expense

Includes but not limited to: operating room, laboratory, tests/X rays, oxygen tent, drugs, medicines, dressings, hot water bottle, ID arm band, facial tissues, lotion, bed pan powder, cotton balls, sanitary belt and pads, disposable slippers, thermometer, water pitcher, support stockings (first pair if medically indicated for diagnosis), air conditioner (when ordered by the attending physician for treatment of disease or injury), pacifiers, special mouth care items, such as toothettes, glycerin swabs.

Morbid Obesity.

A condition diagnosed by a Physician in which the patient who is over 18 years old and has completed bone growth meets one (1) or more of the following criteria:

a. The patient has a body mass index (BMI) exceeding forty (40);
b. The patient has a body mass index greater than thirty-five (35) in conjunction with severe co-morbidities that are likely to reduce life expectancy (i.e. cardiopulmonary complications, severe diabetes, severe sleep apnea, medically refractory hypertension);
c. The patient has a body weight of approximately 100 lbs. over ideal weight as provided in the Metropolitan Life and Weight table;

Body Mass Index (BMI) calculated by dividing the patient's weight in kilograms by height in meters squared. (To convert pound to kilogram, multiply pounds by 0.45. To convert inches to meters, multiply inches by 0.0254)

Nurse Midwife/Practitioner
A person who is certified to practice as a nurse midwife in the state in which the services are performed and who fulfills both of the following requirements:

a. A person licensed by a board of nursing as a Registered Graduate Nurse; and
b. A person who has completed a program approved by the state in which the person is licensed as required in subparagraph A of this Section for the preparation of Nurse Midwives/Practitioner.

Occupational Sickness or Injury
An Occupational Sickness or Injury is any Sickness or Injury that is related to any work that is performed for pay or profit.

Oral Surgery
Includes operations performed in or around the mouth or jaws.

Other Provider
A person or entity, other than a Hospital or Physician, which is duly licensed to render covered services.

Outpatient Pre-Admission Testing
Tests performed on a patient before confinement as an Inpatient provided the following requirements are met:

a. The tests are related to the performance of scheduled Surgery;
b. The tests have been ordered by a Physician after a condition requiring Surgery has been diagnosed and Hospital admission for Surgery has been requested by the Physician and confirmed by the Hospital; and
c. The patient is subsequently admitted to the Hospital, or the confinement is canceled or postponed because a Hospital bed is unavailable or because there is a change in the patient's condition which precludes the Surgery.

Out-of-Pocket Limit
The Out-of-Pocket Limit is the designated limit on the amount of Covered Medical Expenses paid by a Participant during a Benefit Year. Specific Out-of-Pocket Limit amounts are set forth in the Schedule of Benefits. If payments by a Participant for Covered Medical Expenses during a Benefit Year equal or exceed the individual Out-of-Pocket Limit, the Plan shall then pay 100% of Covered Medical Expenses incurred during the remainder of a Benefit Year.

The Out-of-Pocket Limit shall not apply to charges in excess of a Provider's Usual, Customary and Reasonable Charges, Fees and Expenses nor for charges exceeding the Benefit Year limits, or any lifetime limits as set forth in the Schedule of Benefits or those expenses specifically listed as excluded in the Schedule of Benefits.

Partial Day Psychiatric Services
Outpatient psychiatric care in a controlled environment provided when the Participant does not need an Inpatient confinement. This Plan will consider Partial Day Psychiatric Services as Inpatient expenses and will reimburse as such.

Participant
A Student or Dependent participating in the Plan in accordance with the eligibility provisions of the Plan.

Physician
The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform Surgery. It will also include any other licensed medical practitioner if he is operating within the scope of his license and performing a service for which benefits are provided under this Plan when performed by a Physician.

Placed for Adoption or Placement for Adoption
The assumption and retention of a legal obligation for total or partial support of a Child in anticipation of the adoption of the Child.

Plan
The Case Western Reserve University Amended and Restated Medical Care Plan for Students and their Dependents.

Plan Administrator
Those persons who are empowered by the Student Medical Plan Committee to administer and manage the proper execution of the Student Medical Plan.

Plan Sponsor
Case Western Reserve University.

Plan Year
The Plan's fiscal year, the twelve (12) month period beginning on July 1 and ends on June 30 and August 1 and ends on July 31.

Participating Providers
An individual or a network of Providers that have agreed to provide health care services at negotiated discounted rates to Plan Participants. Participating Providers include, but are not limited to, Physician groups and participating pharmacies.

Pregnancy
Pregnancy shall include resulting childbirth, miscarriage or elective abortion.

Prescription Drugs
The following will be considered Prescription Drugs:

a. Federal Legend Drugs. (This is any medicinal substance which the Federal Food, Drug and Cosmetic Act requires to be labeled "Caution -- Federal law prohibits dispensing without prescription".);
b. Drugs which require a prescription under state law but not under federal law;
c. Compound drug. (This is a drug that has more than one (1) ingredient. At least one (1) of the ingredients has to be a Federal Legend Drug or a drug which requires a prescription under state law.); and
d. Injectable insulin.

Prior Authorization
A request made prior to a procedure to verify benefits and medical appropriateness of the procedure. This allows the patient to make an informed decision of potential coverage for the procedure in advance.

Protected Health Information or PHI
"Protected Health Information (PHI)" means information that is created or received by Plan and relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. PHI includes information of persons living or deceased. The following components of the Participant's information also are considered personal health information: a) names; b) street address, city, county, precinct, zip code c) dates directly related to a Participant, including birth date, health facility admission and discharge date, and date of death; d) telephone numbers, fax numbers and electronic mail addresses; e) Social Security numbers; f) medical record numbers; g) health plan beneficiary numbers; h) account numbers; i) certificate/license numbers j) vehicle identifiers and serial numbers, including license plate numbers; k) device identifies and serial numbers; 1) Web University Resource Locators (URLs); m) biometric identifiers, including finger and voice prints; n) full face photographic images and any comparable images, and o) any other unique identifying number, characteristics or code. PHI includes Electronic PHI as defined in 45 C.F.R. & 160.103 that is received from, or created or received on behalf of the Plan.

Provider
A Hospital, Physician, or Other Provider, duly licensed and performing within the scope of any applicable license.

Psychiatrist
A Physician who specializes in psychiatry and has the needed training and experience to diagnose and treat

Mental/Nervous Disorders.

Qualified Medical Child Support Order
An order4, decree, judgment or administrative notice (including a settlement agreement) requiring health coverage for a child; issued by a domestic relations court or other court competent jurisdiction or through an administrative process established under state law and which meets the requirements set forth by federal and state laws an regulations.

Registered Graduate Nurse
A professional nurse who has the authorization to use the title "Registered Nurse" and the abbreviation "R.N.".

Room and Board Charges
Those charges made by a Hospital or institutional Provider for room and board and other necessary services and supplies. The charges must be regularly made at a daily or weekly rate.

Routine Care
Any medical service that is performed for preventative purposes or performed in the absence of a specific illness.

Semi-Private Room Rate
The Room and Board Charges which a Hospital or Provider applies to most beds in its semi-private rooms with two (2) or more beds.

Sickness
Physical illness, disease, alcoholism, drug abuse, or Mental/Nervous Disorder for which treatment is received while the person is covered under the Plan. A recurrent Sickness will be considered one (1) Sickness unless the concurrent Sicknesses are totally unrelated. For purposes of this Plan, the term "Sickness" will include Pregnancy.

Spouse
The lawful Spouse of a participating Student who is not legally separated or divorced from such Student. This includes Domestic Partners. This does not include common law Spouses.

Step Child
One who is the child, natural or adopted, of such person's spouse but who is not the child, natural or adopted, of such person.

Student
For purposes of the Plan, the term “Student” includes those persons who (A) are not cross-registered for classes at the University or its affiliates. (B) not employees of the University who are eligible for Benelect and (C) meet one of the following criteria:

a. A Student of Case Western Reserve University registered for at least one (1) credit hour;
b. Persons associated with Special Programs on the campus of Case Western Reserve University may be eligible for this Student coverage as determined by the Plan Administrator;
c. A Student of The Cleveland Institute of Art or The Cleveland Institute of Music registered for at least one (1) credit hour.

Student Contribution
The amount, if any, specified from time to time by the Plan Sponsor that a participating Student is required to contribute to this Plan in order for such Student and, if applicable, his Dependent(s) to participate hereunder.

Student Medical Plan Committee (Committee)
Those persons who are charged with the oversight of all aspects of the Student Medical Plan.

Substance Abuse Treatment Facility
An institution providing a structured twenty-four (24) hour-a-day Inpatient program for diagnosis, evaluation and effective treatment of alcoholism, and/or drug use or abuse; provides detoxification services; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Graduate Nurse; prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs which is supervised by a Physician; and meets licensing standards applicable to facilities providing such services.

Surgery
Procedures involving cutting of body tissue, debridement or permanent joining of body tissue for repair of wounds, treatment of fractured bones or dislocated joints, endoscopic procedures, and other manual procedures when used in lieu of cutting for purposes of removal, destruction or repair of body tissue.

Surgical Opinion
A written opinion by a qualified Physician as to whether or not to perform Surgery. The opinion is given after an examination of the Participant and X-ray and laboratory work are completed. It must take place before the proposed Surgery is to be done.

Temporomandibular Joint (TMJ) Syndrome
A dysfunction of the temporomandibular joint marked by a clicking or grinding sensation in the joint and often by pain in or about the ears, muscle tiredness and slight soreness upon waking and stiffness of the jaw.

Terminal Illness or Terminally Ill
A Participant with a life expectancy of six (6) months or less as certified in writing by the attending Physician

University
Case Western Reserve University

Usual, Customary and Reasonable Charges, Fees and Expenses or UCR
The prevailing range of charges, fees and expenses charged by Providers of similar training and experience located in the same area, taking into consideration any unusual circumstances of the patient's condition that might require additional time, skill or experience to treat successfully.

Utilization Review Service
The entity which performs the Prior Authorization review pursuant to Article VI.

ARTICLE XVI: GENERAL PLAN INFORMATION

Plan Name
Case Western Reserve University Amended and Restated Medical Care Plan for Students and their Dependents

Plan Sponsor
Case Western Reserve University
10900 Euclid Avenue
Cleveland, OH 44106

Agent for Service of Legal Process
Case Western Reserve University
10900 Euclid Avenue
Cleveland, OH 44106

Plan Sponsor Identification Number
34-1018992

Type of Plan
Medical Care Plan

Funding
Plan Benefits provided by:
Case Western Reserve University
10900 Euclid Avenue
Cleveland, OH 44106

The level of any Student Contribution is set by the Student Medical Plan Committee. The Student Medical Plan Committee reserves the right to change the level of Student Contributions. The Plan Sponsor pays Plan benefits and administration expenses directly from general assets. Contributions received from eligible Participants are used to cover Plan costs and are expended immediately.

Plan Administrator
Case Western Reserve University
10900 Euclid Avenue
Cleveland, OH 44106

Claims Administered By
Aetna Student Health
P.O. Box 981106
El Pasco, TX 79998-1106
877-850-6038

Type of Plan Administration
Self Administered

Source of Plan Contributions
Contributions for Plan expenses are obtained from the Plan Sponsor and from the Participants. The Plan Sponsor evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the Plan Sponsor and the amount to be contributed by the Participants.

ARTICLE XVII: APPLICATION OF STATE LAW

This Plan, as amended from time to time, shall be administered, construed and enforced according to the laws of the State of Ohio and in courts situated in that state.

IN WITNESS WHEREOF, the Plan Sponsor has caused its name to be signed by its proper officer thereunto duly authorized to evidence the adoption of this Amended and Restated Plan on the _____ day of _____, 2017.

CASE WESTERN RESERVE UNIVERSITY

By _____

Its W.A. "Bud" Baeslack III
Provost &
Executive Vice President 10-6-17

CASE WESTERN RESERVE UNIVERSITY

By _____

Its John F Sideras
Chief Financial Officer &
Sr. V.P for Finance 10-18-17

REVIEWED & APPROVED
CWRU
OFFICE OF GENERAL COUNSEL
DATE: 10-2-17

RECEIPT FOR MEDICAL SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

I have received my copy of the Case Western Reserve University Amended and Restated Medical Care Plan for Students and their Dependents Summary Plan Description and Plan Document. I understand that this document is intended only as a general guide to the University's Medical Care Plan for Students and their Dependents and that it in no way is to be considered an agreement or contract or promise of specific benefits. I understand that plan provisions and providers are subject to change at the University's discretion. I agree to read and retain for reference my plan summary and any supplements or amendments that may be provided to me in the future.

SIGNED:_____

DATE:_____