

CLAIMS OFFICE

Welfare and Pension
Administration Service, Inc.
PO Box 34600
Seattle, WA 98124-1600
studentinsurance@wpas-inc.com

Local: 206-374-9439
Toll-Free: 1-866-535-8503

2006-2007 UW STUDENT PLAN ID CARD

The MEGA Life and Health Insurance Company

Present the following information to your medical provider:

Student Name

Student UW ID Number

Student Social Security Number

Policy Number: 2006-1464-1

Claims Office: UW/WPAS Claims Office
PO Box 34600
Seattle, WA 98124-1600
206-374-9439 or 1-866-535-8503

***This card is for informational purposes
only and does not ensure coverage.***

2006–2007

**ACCIDENT AND SICKNESS
INSURANCE PLAN**

A service provided by the
Office of the Vice Provost for Student Life

Developed for the
UNIVERSITY OF WASHINGTON
SEATTLE CAMPUS
Students and Their Dependents

Policy Number
2006-1464-1

Underwritten by
The MEGA Life and Health Insurance Company

Administered by
Welfare and Pension Administration Service, Inc.

TABLE OF CONTENTS

	<u>Page</u>
APPEAL TO ARBITRATION	23
CANCELLATION	4
CLAIM FILING INFORMATION	21
CLAIMS SUBMISSION DEADLINE	21
COVERED MEDICAL BENEFITS	9
DEFINITIONS	19
DENTAL BENEFIT	16
EFFECTIVE DATES	5
ELIGIBILITY	3
EMERGENCY MEDICAL EVACUATION AND REPATRIATION OF REMAINS	15
ENROLLMENT	3
EXCLUSIONS (MEDICAL PLAN)	15
GENERAL LIMITATIONS/PROVISIONS	7
HALL HEALTH PHONE NUMBERS	23
HOSPITALIZATION ON EFFECTIVE DATE	7
IDENTIFICATION CARD	Inside Front Cover
PAYMENT OF PREMIUM	4
PRE-EXISTING CONDITION LIMITATIONS	6
PREMIUM RATES	6
REVIEW OF COMPLAINTS & REJECTED CLAIMS	23
SCHEDULE OF BENEFITS	Center
VISION BENEFIT	19
WHEN YOU ARE NO LONGER ELIGIBLE	23

This is a summary of available medical and dental benefits.
A copy of the Master Policy is available upon request at the
Student Insurance Office, Room 469, Schmitz Hall.

The University of Washington is pleased to present a description of the Student Medical Plan available for students registered at the Seattle Campus, and for their eligible Dependents. The benefits are underwritten by The MEGA Life and Health Insurance Company and administered by Welfare and Pension Administration Service, Inc. (WPAS). Note: This plan is a Blanket Disability Policy. Coverage provided is "excess" only and does not contain a "coordination of benefits" provision.

ELIGIBILITY FOR STUDENTS

University of Washington Seattle Campus students are eligible to enroll in this Plan if all of the following apply:

- You must be formally admitted as a matriculating student by the Graduate or Undergraduate Admissions Office, or the professional schools of Law, Medicine, Dentistry or Pharmacy
- You must be registered as a matriculating student for classes through MyUW or the Office of the Registrar
- You must remain enrolled in classes through the first seven calendar days of instruction during the quarter in which you enroll for coverage.

The following students are not eligible to enroll in this Plan:

- Individuals enrolled in programs administered by UW Educational Outreach including, but not limited to, the Graduate Nonmatriculated Program, Distance Learning, English as a Second Language, Noncredit classes, conferences and institutes, or the Access program
- Individuals enrolled in self-sustaining programs, unless their programs assess the Services & Activities Fee
- UW and other state employees attending classes under the Employee Tuition Exemption Program.

ELIGIBILITY FOR DEPENDENTS

Students who are eligible and who enroll in this Plan may also enroll the following eligible Dependents:

- Insured Student's Spouse or registered same-sex Domestic Partner
- Insured Student's unmarried children under the age of nineteen years.

A child born to or adopted by an Insured Person while this Plan is in force. Newborns will have the same benefits as the insured mother for the first three weeks after birth. The Insured Student must enroll the newborn child within 60 days of birth and pay any additional premium to the Student Insurance office, Room 469, Schmitz Hall within 60 days of the child's birth. We cover adopted children from the date of placement for adoption only if We are notified in writing, and payment of any additional premium is received within 60 days of the date of adoption. Dependent children acquired through marriage or same-sex domestic partner registration must be enrolled within 30 days of marriage or registration.

The term "children" includes an Insured Student's biological children; step-children; children for whom responsibility was assumed through same-sex domestic partner registration; foster children; adopted children from the date of placement in the Insured Student's home and who depend on the Insured Student for their support; children which the Insured Student has been granted legal custody, and children which the Insured Student has legal obligation to provide coverage due to a court order. The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both: 1) Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and, 2) Chiefly dependent upon the Insured Person for support and maintenance.

ENROLLMENT

International Students

International Students are required to have and maintain insurance coverage and must purchase this plan. Limited waivers are available from the International Services Office and must be requested no later than **the 5th calendar day of the quarter**.

Quarterly Requirements

You must be registered during the quarter in which the Plan is **purchased**. To be covered during a quarter when you will not be registered, sign up and pay for the annual option at the beginning of a quarter when you are registered. In all quarters, annual coverage only runs through September 23, 2007.

Note: If you purchase the plan on a quarterly basis, benefits are paid during that quarter term only. You must renew the plan on MyUW or in person at Student Fiscal Services for coverage to continue in subsequent quarters.

How to Enroll

Note: TA/RA/SA Appointees – Do not sign up for this plan through MyUW.

You may enroll yourself and your spouse or registered same-sex domestic partner and/or children in the Plan in the Personal Services section of MyUW, or in person at Student Fiscal Services in Schmitz Hall. Enrollment begins with the pre-registration period and ends on the 7th calendar day of the quarter. If you enroll in the Plan during pre-registration, the premium will be included on your tuition statement sent after the quarter begins. If you enroll in the Plan after the quarter begins, you may not receive an adjusted bill. **You will not be enrolled in the plan by just sending in the premium.**

IMPORTANT: After the 7th calendar day of the quarter, you may not enroll in the plan or change your coverage choice. If you do not cancel your insurance by this time, you will be considered enrolled in the plan and will be required to pay the premium. Annual plan enrollment cannot be cancelled in subsequent quarters; it can only be cancelled in the first 7 calendar days of the quarter in which it is initially purchased.

Domestic Partners

If you wish to enroll yourself and your same-sex Domestic Partner and/or your same-sex Domestic Partner's child(ren) in this Plan, you must be registered in the City of Seattle or other jurisdiction where domestic partner registration is offered. When claims are submitted you will be asked to submit a copy of the City of Seattle Domestic Partnership Certificate or certificate from other jurisdiction where domestic partner registration is offered.

To make enrollment changes

You may add, cancel or change your insurance selection on MyUW, or by contacting Student Fiscal Services, Room 129 Schmitz Hall, in person, prior to the 7th calendar day of the quarter. You may not receive an adjusted billing statement. **No changes may be made to your insurance selection after the 7th calendar day of the quarter, except for newly acquired Dependents.**

Adding Newly Acquired Dependents

You may add newly acquired Dependents during the quarter by contacting the Student Insurance Office, Room 469, Schmitz Hall. You will be required to pay a pro-rata premium based on when your newly acquired Dependent is enrolled (e.g., date of marriage or birth, or placement for adoption).

Note: You must enroll your newly acquired Dependent within 30 days of marriage or same-sex domestic partner registration or 60 days of birth or placement for adoption in order to enroll them off quarter.

CANCELLATION

Cancellation of coverage with a prorata refund of premium is not allowed except in the event the Insured student or spouse enters the military service on full time active duty.

Cancellation of the policy may also occur if your registration is canceled and back-dated to within the first 7 calendar days of the quarter it is purchased.

The annual plan cannot be cancelled in subsequent quarters; it can only be cancelled in the first 7 calendar days of the quarter in which it is initially purchased.

PAYMENT OF PREMIUM

The premium is due on the tuition-due date, which is usually the third Friday of the Quarter. Failure to pay the premium by the tuition-due date will result in subsequent billings and eventually a hold may be placed on your records if the premium is not paid.

Non-payment of the premium will not cancel your policy. You must cancel coverage by the 7th calendar day of the quarter on MyUW or at Students Fiscal Services.

EFFECTIVE DATES

Dates This Policy Is Effective

This is a one-year policy that begins on September 25, 2006 and ends on September 23, 2007. The benefits described in the brochure are applicable during this term only. You may purchase the Plan on a quarterly or annual basis.

Purchasing "Annual" Coverage

If you purchase the "annual" coverage, you will be covered from the date listed below for the quarter in which you purchase the "annual" coverage and continuing until the end of this Policy Year (September 23, 2007). A \$25 fee will be charged to students who elect annual coverage and whose elections are changed in subsequent quarters. This fee is assessed by The University of Washington for administrative services and is not remitted to The MEGA Life and Health Insurance Company.

Purchasing Quarterly Coverage

If you purchase coverage quarterly, the quarterly policy terms are as follows:

2006 Autumn Quarter: September 25, 2006–January 2, 2007

2007 Winter Quarter: January 3, 2007–March 25, 2007

2007 Spring Quarter: March 26, 2007–June 17, 2007

2007 Summer Quarter: June 18, 2007–September 23, 2007

PREMIUM RATES

Per Quarter

The premium rates below, except the Annual rates applicable at Autumn Quarter, include the cost of administrative services (\$5.00) provided by the University.

Coverage Classification	Premiums Per Plan Quarter**
A. Student Only	\$389.00
B. Student & Spouse or Domestic Partner	\$962.00
C. Student, Spouse or Domestic Partner and Child(ren)	\$1451.00
D. Student and Child(ren)	\$878.00

****IMPORTANT:** If you choose to purchase coverage on a Per Academic Quarter basis, you must be registered during the quarter for which it is purchased and remain enrolled in classes through the first seven calendar days of instruction during the quarter. To keep coverage in effect when not enrolled, choose the Annual Plan while pre-registering for the last Academic Quarter that you will attend the University, and pay the applicable premium for coverage through September 23, 2007.

Per "Annual" Enrollment (through end of Policy Year)

	Annual at Autumn Qtr. (4 Qtrs.)	Annual at Winter Qtr. (3 Qtrs.)	Annual at Spring Qtr. (2 Qtrs.)	Annual at Summer Qtr. (1 Qtr)
A.	\$1536	\$1167	\$778	\$389
B.	\$3828	\$2886	\$1924	\$962
C.	\$5784	\$4353	\$2902	\$1451
D.	\$3492	\$2634	\$1756	\$878

PRE-EXISTING CONDITION LIMITATION

Pre-existing condition means 1) the existence of symptoms within the 3 months immediately prior to the Insured's Effective Date under the policy; or, 2) any condition which is diagnosed, treated or recommended for treatment within the 3 months immediately prior to the Insured's Effective Date under the policy.

Pre-existing Conditions will be excluded for a 3-month period, except for individuals who have been insured under another similar health plan for at least 3 months immediately prior to becoming insured under this Policy. Credit will be given for the period of time an Insured was covered under the immediately preceding health plan for periods less than the 3-month period.

The pre-existing condition limitation may not apply in full or in part if you had creditable coverage in the 62 days prior to your effective date of coverage in this plan.

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

Exceptions

The pre-existing condition exclusion does not apply to any of the following: (a) abortion; (b) pregnancy, including complications, if such condition is covered under this Plan; (c) a covered newborn infant dependent child who, as of the last day of the 60-day period beginning with the date of birth, is covered under any immediately preceding health plan; or (d) a covered adopted dependent child under the age of 18, who, as of the last day of the 30-day period beginning on the date of adoption or placement for adoption, is covered under any immediately preceding health plan (except this shall not apply to coverage the adopted child may have had before such adoption or placement).

Genetic information will not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information. (Genetic testing is not covered under the plan.)

If a claim was paid that was related to a pre-existing condition, payment will not constitute a waiver of this exclusion for that claim or for any subsequent claim if we later determine that the condition was pre-existing.

HOSPITALIZATION ON EFFECTIVE DATE

If you or your eligible Dependent is confined to a Hospital or other facility at the time coverage would otherwise begin, such coverage will not begin until after discharge, except for newborn and adoptive children as specified in this Plan (if you have applied for coverage as specified in the enrollment section).

GENERAL LIMITATIONS/PROVISIONS

No benefits will be provided under this plan for marital and family counseling, prosthetic appliances, orthotic devices or over-the-counter drugs and take home medications.

Outpatient Expense Benefits

If by reason of Injury or Sickness, an Insured Person incurs the following Outpatient Services, we will pay the Covered Percentage of the Covered Medical Expenses incurred as shown in the Schedule of Benefits:

- A Physician's office while not Hospital Confined
- A Hospital outpatient department
- Emergency room, is subject to a copayment of \$25.00 per visit which will be waived if the Insured Person is admitted to the Hospital
- Diagnostic x-ray and laboratory testing. (When x-rays or laboratory tests are performed at HHPCC but referred to and/or billed from non-Hall Health providers, Insured Students are responsible for the Deductible/applicable copayments.)
- Clinical lab
- Radiological lab or other similar facility licensed by the state
- An Ambulatory Surgical Center for covered surgery
- Blood-borne pathogen protocol
- Physiotherapy (services must be referred by the attending physician). After the twelfth visit, a medical review will be performed to ensure that visits are medically necessary.
- Home phototherapy: the services and supplies furnished by an approved home phototherapy provider will be covered for newborn hyperbilirubinemia
- Radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy
- Surgical dressings, splints, casts, and other devices used to correct fractures and dislocations.
- Services billed by a non-network provider are reimbursed at the non-network rate. As an exception, services provided outside the Western Washington area will be paid at the network provider levels if a Coalition of America provider is used. Western Washington area is defined as King, Snohomish, Pierce and Kitsap counties. This exception will not apply to outpatient mental health services or prescription drugs. These services will be paid as indicated on the Schedule of Benefits. Locate a Coalition of America provider by calling 1-800-878-7896 or by visiting www.coalitionamerica.com pin #3728.

Level of Coverage for Students Covered as Eligible Dependents under this Plan

If you are a student, but covered under this Plan as an eligible Dependent, benefits will be paid at the Dependent levels.

Mental Health Providers Covered Under This Plan

Treatment may be provided by any properly licensed Physician, psychologist, psychiatrist, certified social worker and counselor and credentialed ARNP or other provider as required by law.

Outpatient Mental Health (Insured Student only)

- Each Insured Student on this Plan may receive a maximum of 15 visits per Policy Year from all eligible Mental Health service providers combined, 10 of which must be received at HHPCC or the Student Counseling Center in Schmitz Hall.
- Services received at HHPCC and the Student Counseling Center in Schmitz Hall for the first 3 visits will be paid at 100% of charges per Insured Student per Policy Year. If more than 3 visits are authorized at the HHPCC and the Student Counseling Center, the Plan will pay 80% of the charges up to 12 additional visits per Insured Student per Policy Year. There will be no Deductible charged. Insured Students must see a recognized Mental Health provider when seeking services at the HHPCC or Student Counseling Center in Schmitz Hall.
- For all other covered Mental Health providers, the \$500 Policy Year Deductible will apply and services will be paid thereafter at 60% of Usual & Customary up to 5 visits per Policy Year.

Outpatient Mental Health

(for Dependents only, including students who are covered on this Plan as a spouse, same-sex domestic partner or a child)

- An additional \$500 Policy Year Mental Health Deductible is required for any Insured Dependent seeking Outpatient Mental Health Services
- After the additional \$500 Policy Year Deductible has been met, the Plan will pay 60% of Usual and Customary Expense for non-network providers, up to a maximum of 15 visits per Insured Dependent per Policy Year. There are no in-network providers available.
- Note: Only UW students are seen at the Student Counseling Center. Students covered as Dependents on this Plan will be subject to the \$500 Deductible if they receive services at HHPCC or the Student Counseling Center in Schmitz Hall.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum means the maximum dollar amount an Insured Person is responsible to pay during a Policy Year. After an Insured Person has reached the Out-of-Pocket Maximum of \$2,500 for network providers or \$5,000 per Policy Year for non-network providers, We cover most benefits at 100% for the remainder of the Policy Year. Some benefits, however, will always remain payable at the percentage shown in the Schedule of Benefits. The Out-of-Pocket Maximum is met by accumulated Coinsurance and does not include the Deductible or any copayments under the Plan. Penalties, balances remaining after maximums have been met, and amounts above the Usual and Customary Expense do not count toward the Out-of-Pocket Maximum. Covered Medical Expenses for outpatient rehabilitation, neurodevelopmental therapy, and mental health services do not count towards the Out-of-Pocket Maximum.

Prescription Drug Expense Benefit

The drugs must be prescribed by a Physician. We only cover drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment of a covered Injury or Sickness for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: 1) American Medical Association Drug Evaluations; 2) American Hospital Formulary Service Drug Information; 3) United States Pharmacopoeia Drug Information; or 4) it is recommended by a clinical study or review article in two major peer-reviewed professional journals that present data supporting the use or uses to be generally safe and effective.

However, Covered Medical Expenses do not include experimental or investigational drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Prescription Drug Benefit: Formulary/NonFormulary

For purposes of the following prescription drug sections, note that formulary and nonformulary are defined as:

- A formulary prescription is included on the approved list of drugs most commonly utilized by Rubenstein Pharmacy and the UWMC
- A nonformulary prescription is not included on this list, and would need to be special-ordered.

Prescriptions at Rubenstein Pharmacy (located in the Hall Health Primary Care Center)

- Prescriptions are filled or refilled up to a 35-day supply for each medication, once per month
- For generic formulary prescriptions, the Insured Student pays 20% or a \$15 Copayment per prescription, whichever is greater; the Plan pays the balance up to a maximum of \$200 per prescription
- For brand-name formulary prescriptions, the Insured Student pays 30% or a \$25 Copayment per prescription, whichever is greater; the Plan pays the balance up to a maximum of \$200 per prescription
- For nonformulary prescriptions, the Insured Student pays 40% or a \$30 Copayment per prescription, whichever is greater; the Plan pays the balance up to a maximum of \$200 per prescription
- Prescriptions which are subject to the Quarterly Deductible and Coinsurance include those filled or refilled:
 - More than once per month, or
 - During a quarter not registered, or
 - For those covered on the Plan as a Dependent.

Prescriptions at UW System Pharmacies

UW System Pharmacies include UWMC, Roosevelt, and Harborview. The Insured Person must pay the entire cost of the prescription to the pharmacy and then submit a receipt and claim form to WPAS for reimbursement. Coverage will be as follows, after the Quarterly Deductible has been satisfied:

- Prescriptions are filled or refilled up to a 35-day supply for each medication, once per month.
- For generic formulary prescriptions, the Insured Student or Dependent pays 30% or \$15 Copayment per prescription, whichever is greater, to a maximum of \$200 per prescription.
- For brand name formulary prescriptions, the Insured Student or Dependent pays 40% or \$25 Copayment per prescription, whichever is greater, to a maximum of \$200 per prescription.
- For nonformulary prescriptions, the Insured Student or Dependent pays 50% or \$30 Copayment per prescription, whichever is greater, to a maximum of \$200 per prescription.

Prescriptions at Other Locations (not Rubenstein or UWMC)

Prescriptions are filled or refilled up to a 35-day supply for each medication, once per month. Prescription Drugs filled at non-Hall Health and non-UWMC locations will be covered, after the Quarterly Deductible has been met, the Plan will pay 50% of the Usual and Customary Expense to a maximum of \$200 per prescription. The Insured Person must pay the entire cost of the prescription to the pharmacy and then submit a receipt and claim form to WPAS for reimbursement.

Quarterly Deductible

The Deductible is calculated on a quarterly basis. Only one Deductible will be charged per quarter, per Insured Person, regardless of whether services are received from UWMC, Harborview, HHPCC, or any other Physicians or Hospitals.

COVERED MEDICAL BENEFITS

Alcoholism/Chemical Dependency

We will pay the Covered Percentage of the Covered Medical Expenses incurred, as shown in the Schedule of Benefits, for any Medically Necessary inpatient and outpatient treatment, including detoxification and supporting services provided by an Approved Treatment Facility. Covered benefits may include medical evaluations, room and board (inpatient only), psychotherapy (individual and family member), counseling (individual and family member), behavior therapy, recreation therapy, family therapy, prescription drugs and supplies prescribed by an Approved Treatment Facility. Benefits will be provided to a maximum of \$13,000 in any consecutive twenty-four month period. Any Chemical Dependency Benefits received by an Insured Person during the previous twenty-four month period under the Plan or any prior contract with Us will be charged against the two-year benefit limit.

Braces, Appliances and Durable Medical Equipment

If, by reason of injury or sickness, an Insured Person requires the use of durable medical equipment or braces and appliances, We will pay the covered percentage of covered medical expenses incurred by the Insured Person, subject to the Deductible shown in the Schedule of Benefits provided the item is: 1) ordered by a physician; 2) is designed for repeated use; 3) is mainly and customarily used for medical purposes; 4) is not generally of use to a person in the absence of a disease or injury; 5) is usable only by the patient; 6) is not primarily for the comfort or hygiene of the patient; and 7) not for prevention purposes or exercise. We pay the covered percentage of the covered medical expenses incurred by the Insured Person for the purchase of such braces, appliances and durable medical equipment when the purchase price is less costly than rental. We do not pay for the replacement of braces, appliances or durable medical equipment or for batteries. (Examples of covered items: wheelchair, breathing machine, brace, crutch, splints, and casts. Examples of non-covered items include but not limited to: air conditioners, humidifiers, spas or whirlpool baths, orthopedic shoes, adjustable beds, orthopedic chairs, communication devices, heating pads, bed wetting devices, deluxe items or personal hygiene items.)

Diabetes Treatment

We cover charges for the following appropriate and Medically Necessary equipment and supplies incurred by an Insured Person for the care and treatment of diabetes, if recommended or prescribed by a Physician. Coverage includes, but is not limited to: insulin, syringes, injection aids, blood glucose monitor strips, test strips for blood glucose monitors, visual reading and urine test strips, insulin pumps and accessories to the pumps, insulin infusion devices, prescription oral agents for controlling blood sugar levels, foot care appliances for prevention of complications associated with diabetes and glucagon emergency kits. We also cover charges for Expenses incurred for outpatient diabetes self-management training and education, including medical nutrition therapy, as ordered by a Physician and provided by an approved provider with expertise in diabetes.

We treat charges for equipment the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits. We treat charges for supplies the same way we treat Covered Medical Expenses for Prescriptions if acquired at a pharmacy as shown in the Schedule of Benefits.

Home Health Care and Hospice Care

Benefits shall be provided on the same basis as any other Sickness or Injury for home health care and hospice care for Insureds who are homebound and would otherwise require hospitalization. Benefits shall consist of services rendered by home health and hospice agencies licensed by the department of social and health services when recommended by a Physician.

Home health care coverage shall provide benefits for a maximum of one hundred thirty (130) health care visits per calendar year. However, a visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment constitutes one visit.

Hospice care coverage shall provide benefits for terminally ill patients for a period of care of not more than six months. Limited extensions will be granted if the Insured Person is facing imminent death and certified in writing by the attending physician.

Benefits shall be subject to all Deductible, coinsurance, limitations and any provisions of the Policy.

Infusion Therapy

We will cover charges for services and supplies provided for infusion therapy when furnished by an approved infusion therapy provider. We cover a maximum of \$25,000 per Policy Year under this infusion therapy benefit and under the Home Health and Hospice benefits combined. Drugs and supplies used in conjunction with infusion therapy will be provided only under this infusion therapy benefit. No other benefits for infusion therapy will be provided under this Plan. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits.

Mammography

We cover charges for screening and diagnostic mammography services when recommended by an Insured Person's Physician or advanced registered nurse practitioner. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits.

Maternity

We will pay benefits for an Insured Person's Covered Medical Expenses for maternity care, including Hospital, surgical and medical care. We cover charges for a minimum of 48 hours of inpatient care following an uncomplicated vaginal delivery and a minimum of 96 hours of inpatient care following an uncomplicated cesarean section for a mother and her newborn child in a health care facility, unless the attending Physician in consultation with the mother, makes an alternative decision on the length of inpatient stay. The decisions must be based on accepted medical practice. For a mother and newborn child who remain in the Hospital for the minimum length of time stated above, We will pay for post-delivery care as ordered by the attending Physician in consultation with the mother. For a mother and newborn child at time of discharge, the attending Physician in consultation with the mother will make a determination of the type and location of follow-up care based on accepted medical practice, including in-person care, services of a midwife and home health care.

We also cover routine nursery care furnished to a baby after its birth and one routine well-baby examination by a Physician furnished to the baby before the insured mother is discharged from the Hospital. In addition, the newborn child will have the same coverage as the insured mother for the first three weeks after birth. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits.

Phenylketonuria Treatment

Benefits shall be provided on the same basis as any other Sickness for the mineral and vitamin-enriched formulas necessary for the treatment of phenylketonuria for the Insured. Benefits shall be subject to all Deductible, coinsurance, limitations and any provisions of the Policy.

Pre-Admission Testing

Notwithstanding any provision in this Plan to the contrary, We will pay benefits for Covered Medical Expenses made by a Hospital for use of its outpatient facilities for tests ordered by a Physician. The tests must be performed as a planned preliminary to the Insured Person's admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Insured Person is physically present at the Hospital for the tests. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits.

Prenatal Testing

We cover charges for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy when such services are determined to be Medically Necessary as determined by Washington State Board of Health Standards. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits.

Benefits	Network Provider ¹	Non-Network Provider ²
Per Condition Aggregate Maximum Benefit	\$200,000 per Policy Year	
Deductible	\$75 per quarter; \$300 per Policy Year maximum The Deductible is waived for currently registered students for services received at HHPCC	
Out-of-Pocket Maximum (per Policy Year)³	\$2,500	\$5,000
Inpatient Expenses		
Inpatient Hospital/Surgical (Services include Hospital Room & Board Expense, Miscellaneous Hospital Expense, In Hospital Doctor Visit and Medical Expense, Pre-Admission Test, Consultant Expense, Surgery Expense, Anesthetist Expense, Assistant Surgeon Expense, and Multiple Surgical Procedure Expense)	\$300 copay per admission 80% of Preferred Allowance	\$400 copay per admission 60% of U&C
Outpatient Expenses		
Outpatient/Surgical (Services include Doctor's office visit, physical therapy, diagnostic x-ray and laboratory tests*, Hospital Outpatient Department and other services (page 6), Anesthetist Expense, Assistant Surgeon Expense, and Multiple Surgical Procedure Expense)	80% of Preferred Allowance	60% of U&C
Emergency Room (Copay is waived if admitted)	\$25 copay 80% of Preferred Allowance	\$25 copay 80% of U&C if a true Medical Emergency as defined, otherwise covered at 60% of U&C if not a true Medical Emergency
Mental Health Condition Expenses		
Inpatient Mental Health Conditions (maximum of 20 days/Policy Year)	\$300 copay per admission; 80% of Preferred Allowance	\$400 copay per admission; 60% of U&C
Outpatient Mental Health Conditions (Network Providers for this benefit are HHPCC or the Student Counseling Center only (refer to page 7) ⁴)	100% up to a maximum of 3 visits, then 80% up to an additional 12 visits/Policy Year (currently registered students only; non-students/dependents see page 7)	\$500 Deductible/Sickness, 60% of U&C (maximum visits for students is 5; maximum visits for dependents is 15)
Prescription Drug Expenses⁺ (Includes mental health drugs, diabetic supplies and contraceptives)	Rubenstein Pharmacy Insured Student pays:	Insured Student pays:
Generic Formulary Prescriptions (maximum of \$200/prescription)	20% or \$15 Copay whichever is greater	50% of U&C
Brand Name Formulary Prescriptions (maximum of \$200/prescription)	30% or \$25 Copay whichever is greater	50% of U&C
Nonformulary Prescriptions (maximum of \$200/prescription)	40% or \$30 Copay whichever is greater	50% of U&C
	UMC and UWP Pharmacies Insured Person pays:	Insured Person pays:
Generic Formulary Prescriptions (maximum of \$200/prescription)	30% or \$15 Copay whichever is greater	50% of U&C
Brand Name Formulary Prescriptions (maximum of \$200/prescription)	40% or \$25 Copay whichever is greater	50% of U&C
Nonformulary Prescriptions (maximum of \$200/prescription)	50% or \$30 Copay whichever is greater	50% of U&C
Additional Expenses	Plan Pays	Plan Pays
Abortion	80% of Preferred Allowance	80% of U&C
Alcohol/Chemical Dependency (maximum of \$13,000, page 9)	100% of Preferred Allowance \$300 copay per inpatient admission	100% of U&C \$400 copay per inpatient admission
Ambulance	Not Available	60% of U&C
Braces, Appliances and Durable Medical Equipment	Not Available	60% of U&C
Diabetic Treatment and Equipment (refer to page 10)	Paid as any other Sickness	Paid as any other Sickness
Diabetic Supplies (Pharmacy) (refer to page 10)	See above prescription drug benefit	See above prescription drug benefit
Home Health Care (maximum of 130 visits/Policy Year)	Not Available	60% of U&C
Hospice (maximum of 6 months per lifetime)	Not Available	60% of U&C

¹ Network Providers are limited to Hall Health Primary Care Center (HHPCC), UW Medical Center (UWMC), Harborview, UW Physicians, University Physicians Network, Seattle Cancer

² Exception: services provided outside the Western Washington area will be paid at the network provider levels if a Coalition of America provider is used. The Western Washington area is defined as King, Snohomish, Pierce and Kitsap counties. The exception does not apply to outpatient mental health and prescription drugs which will be paid as indicated above. Locate a Coalition of America provider by calling 1-800-878-7896 or by visiting www.coalitionamerica.com pin #3728.

³ All Deductibles and Copayments do not apply toward the Out-of-Pocket Maximum (see Out-of-Pocket Maximum on page 7 for other exceptions).

⁴ At the HHPCC and the Student Counseling Center at Schmitz Hall the Deductible does not apply for students. Only students are seen at the Student Counseling Center at Schmitz Hall.

Benefits	Network Provider ¹	Non-Network Provider ²
Immunizations, for Hepatitis A and Hepatitis B	80% of Preferred Allowance	60% of U&C
Infusion Therapy (maximum of \$25,000/Policy Year in combination with the Home Health and Hospice Expense Benefits)	80% of Preferred Allowance	60% of U&C
Midwifery	80% of Preferred Allowance	80% of U&C
Neurodevelopmental Therapy Services (maximum of \$1,000/Policy Year)	80% of Preferred Allowance	60% of U&C
Off-label Uses of Prescription Drugs	Paid as any other Prescription Drug	
Skilled Nursing Facility (maximum of 90 days/Policy Year)	\$300 copay per admission 80% of Preferred Allowance	\$400 copay per admission 60% of U&C
Well Baby Care (maximum of \$5,000/Policy Year, page 15)	Paid as any other Sickness	

* When x-rays and laboratory tests are performed at HHPCC but referred to and/or billed from non-HHPCC, deductible and 60% copayment at non-network facilities and 80% at network facilities apply.

* Prescriptions are subject to the quarterly deductible and coinsurance if filled or refilled during a quarter not registered for classes.

U&C stands for Usual & Customary charges (see definitions for additional details).

Neurodevelopmental Therapy Services

We cover charges for Medically Necessary neurodevelopmental therapy treatment to restore and improve function for children age 6 and under. This benefit includes maintenance services where significant deterioration of the Insured Person's condition would result without the service. Benefits will be provided as follows: (a) physical therapy, speech therapy and occupational therapy will be covered on an outpatient basis; and (b) inpatient Hospital and skilled nursing facility benefits will be covered for a neurodevelopmental therapy admission when care cannot be safely provided on an outpatient basis. The Insured Person's Physician must submit, for advance approval and periodic review, a written treatment plan, which specifically describes the services to be provided. No benefits will be provided for custodial care, maintenance (except as specified), non-medical self-help, recreational, educational or vocational therapy, gym, or swim therapy. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness, as shown in the Schedule of Benefits, up to maximum of \$1,000 per Policy Year.

Reconstructive Breast Surgery

Benefits will be paid for reconstructive breast surgery (including prosthesis) resulting from a mastectomy which resulted from disease, illness, or Injury; regardless of when the mastectomy or the condition which made the mastectomy necessary was covered by this policy. Benefits will be paid for all stages of one reconstructive breast reduction on the nondiseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. Benefits for Reconstructive Breast Surgery shall be commensurate with the Hospital and surgical benefits otherwise provided by this policy. Benefits shall be limited by any maximum amounts specified in the Schedule of Benefits, any Deductible and any coinsurance provision.

Skilled Nursing Facility

If an Insured Person requires continuing treatment in a Skilled Nursing Facility or a Rehabilitation Center following hospitalization, We will pay the Covered Percentage of the Covered Medical Expenses incurred by the Insured Person for treatment in such Skilled Nursing Facility or Rehabilitation Center. We cover room and board, routine nursing care and other services and supplies during the confinement including physical therapy, speech therapy and occupational therapy. The services must be Medically Necessary as a continuation of treatment for the condition for which the Insured Person was previously hospitalized. The Insured Person must be admitted to the Skilled Nursing Facility or Rehabilitation Center within twenty-four (24) hours following a Medically Necessary Hospital stay. We cover such charges the same way we treat Covered Medical Expenses for any Hospital Confinement, as shown in the Schedule of Benefits, up to a maximum of 90 days per Policy Year.

Sterilization

We cover charges for sterilization procedures. But, We do not cover charges for the reversal of a sterilization procedure. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness.

Transplant

We cover charges for Medically Necessary services and supplies after meeting the pre-existing condition requirements relating to the following eligible organ transplants: (1) heart; (2) heart/lung combined; (3) kidney; (4) kidney/pancreas; (5) lungs – single/bilateral; (6) liver; (7) cornea; (8) bone marrow or other form of stem cell rescue.

We do not cover any donor expenses.

Well Baby Care

We cover charges for Well-Baby Care furnished to an Insured Dependent up to and including age 5. We limit what we pay to \$5,000 each Policy Year, including any amounts paid toward newborn infant care in the Hospital as described in Maternity Care Expense Benefit. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits.

Wellness Health Examinations

Routine physical examinations are not covered except We will pay the Covered Percentage of the Covered Medical Expenses incurred for preventive care only as follows: (a) routine cholesterol testing and routine testing for sexually transmitted diseases. Covered Medical Expenses may include (1) one cholesterol test and one battery of tests for sexually transmitted diseases including Chlamydia, Gonorrhea, Herpes and HIV/AIDS per Policy Year, or (2) two cholesterol tests per Policy Year, or (3) two battery of tests for sexually transmitted diseases including Chlamydia, Gonorrhea, Herpes and HIV/AIDS per Policy Year; (b) immunizations for Hepatitis A and Hepatitis B for all Insured Persons; (c) one routine annual pap and pelvic examination per Policy Year; (d) one annual male preventive exam per Policy Year.

We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits. No benefits will be paid for routine physical examinations, routine testing, preventive testing or treatment and screening exams.

Women's Health Care Services

We will pay the Covered Percentage of the Covered Medical Expenses for Women's Health Care Services when ordered by a directly accessed Women's Health Care Practitioner. "Women's Health Care Services" includes, but is not limited to maternity care, reproductive health services, gynecological care, general examinations and preventive care as medically appropriate, and medically appropriate follow-up visits for those services. General examinations, preventive care and medically appropriate follow-up care are limited to maternity, reproductive health services, gynecological care or other health services that are particular to women such as breast examinations. We cover such charges the same way we treat Covered Medical Expenses for any other Sickness as shown in the Schedule of Benefits.

EMERGENCY MEDICAL EVACUATION & REPATRIATION OF REMAINS

Benefits will be provided for Insured International Students on non-immigrant visas and their eligible Insured Dependents, as required by the U.S. Information Agency.

Emergency Medical Evacuation

We will pay 100% of the actual expense up to a lifetime maximum of \$10,000 to transport an Insured Person to their home country or country of regular domicile. Emergency Medical Evacuation means after being treated at a local Hospital, the Insured Person's medical condition warrants transportation to his/her home country to obtain further medical treatment to recover. Covered Expenses are Expenses up to the maximum for transportation, medical services and medical supplies necessarily incurred in connection with Emergency Medical Evacuation of the Insured Person. All transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company.

Repatriation of Remains

In the event of the death of an Insured Person, We will pay the actual charges for preparing and transporting that person's remains to his or her foreign home up to a maximum of \$7,500. This will be done in accord with all legal requirements in effect at the time the body remains are to be returned to his or her home.

MEDICAL PLAN EXCLUSIONS

This Plan does not cover nor provide benefits for:

1. Acupuncture—Services, supplies and/or treatment
2. Braces, appliances and Durable Medical Equipment, except as specifically provided in the Policy
3. Bungee jumping or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
4. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children
5. Custodial care services and supplies related to custodial care such as care provided in rest homes, health resorts, homes for the aged, halfway houses or places mainly for domiciliary or custodial care. Extended care in treatment or substance abuse facilities also are not covered for domiciliary or custodial care
6. Dental treatment except as specifically provided in the Schedule of Benefits
7. Hearing examinations or hearing aids; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process
8. Immunizations services and supplies related to immunizations, except as specifically provided in a benefit section; preventive medicines or vaccines, except where required for treatment of a covered Injury
9. Injury caused by, contributed to or resulting from alcoholism and drug addiction
10. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation
11. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance
12. Injury sustained while participating in any intercollegiate, contest or competition; traveling to or from such sport, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest or competition
13. Learning disabilities (excluding ADD/ADHD) and behavioral problems including services and supplies

14. Naturopathic services
15. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting
16. Prescription drug services – no benefits will be payable for: (a) therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; except as specifically provided in the policy; (b) drugs labeled “Caution – limited by federal law for investigational use: or experimental drugs; (c) products used for unapproved cosmetic indications; (d) anorectics – drugs used for the purpose of weight control; (e) fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene or Viagra
17. Reproductive/infertility services including but not limited to: family planning; fertility tests; infertility for male/female including any services or supplies rendered for the purpose or with the intent of inducing conception. Examples of fertilization procedures are: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive ability; premarital examinations; impotence, organic or otherwise;
18. Research for examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study
19. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the Policy
20. Sexual dysfunction–Services, surgery or related expenses or supplies
21. Sexual reassignment surgery–Services, surgery or related expenses or supplies
22. Services provided normally without charge by the Health Service of the Policyholder or services covered or provided by the student health fee
23. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery
24. Suicide or attempted suicide while sane or insane (including drug overdose) or intentionally self-inflicted injury
25. Elective surgery and elective treatment
26. Treatment in a governmental Hospital unless there is a legal obligation for the Insured Person to pay for such treatment
27. Vision services and supplies related to eye refractions or eye examinations, eyeglasses or contact lenses or prescriptions or fitting of eyeglasses and radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy or similar type procedures or service except when due to a disease process except as specifically provided in the Vision Benefit section
28. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered)
29. Weight management services and supplies related to weight reduction programs, weight management programs, related nutritional supplies, surgery or treatment for obesity, surgery for removal of excess skin or fat. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

DENTAL BENEFIT

Annual Maximum

\$300 per Policy Year

Annual Dental Deductible

\$25 per Policy Year per Insured Person

\$75 per Policy Year per family

Schedule of Benefits

Diagnostic & Preventive Services

We will pay the following Covered Benefits, after the Annual Dental Deductible, at 100% of the Usual & Customary Expense incurred subject to the Annual Maximum. Dentist means any dental or medical practitioner, who is properly licensed or certified under the laws of the state and is acting within the scope of his or her license, to: (a) render dental services; (b) perform dental surgery; or (c) administer anesthetics for dental surgery. Dentist also includes a licensed dentist who is acting within the scope of his or her license.

Covered Benefits	Limitations
Dental x-rays	Once every three year period for complete series (4 bitewing x-rays and up to 10 periapical x-rays) or panoramic film x-rays. Supplementary bitewing x-rays are covered once every 6-month period.
Oral routine examinations	Two exams per Policy Year.
Oral hygiene instruction	Three sessions per lifetime.
Fissure sealants for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface	Once every three- year period per tooth for Dependent children through age 13.
Prophylaxis (cleaning, scaling and polishing)	Two treatments per Policy Year.
Space maintainers when used to maintain space for eruption of permanent teeth	Only children under age 12 covered.
Topical application of fluoride	Two treatments per Policy Year, through age 18.

Diagnostic & Preventative Benefit Exclusions

1. Diagnostic services and x-rays related to temporomandibular joints (jaw joints)
2. Consultations
3. Study models
4. Caries susceptibility tests
5. Plaque control program
6. Oral hygiene instruction (except as listed above), dietary instruction and home fluoride kits
7. Cleaning of a prosthetic appliance
8. Replacement of a space maintainer previously paid for by the Company.

Injury to Teeth

This Plan will pay, after a \$100 Deductible per Injury, 70% of Usual and Customary Expense incurred, up to a \$1,500 Dental Maximum, arising as a direct result of an accidental bodily Injury to sound, natural teeth. The accidental bodily Injury must have occurred while the Insured Person was eligible. An accidental bodily Injury does not include teeth broken or damaged during the act of chewing or biting on foreign objects. Coverage includes necessary procedures for dental diagnosis and treatment rendered within 30 days following the date of the Accident and all services must be provided within 12 months of the date of the Accident.

Dental Benefit Exclusions

No Benefits will be provided under this provision for the following:

1. All other services not specifically included in the Plan as covered dental benefits
2. Behavior management
3. Charges by any person other than a licensed dentist or licensed dentist, except for a licensed hygienist
4. Charges for any services in excess of the percentages and maximums listed in the Schedule of Benefits
5. Charges incurred to comply with Occupational Safety and Health Administration (OSHA) requirements
6. Charges that would not have been made or that the Insured Person would have had no obligation to pay in the absence of this Plan
7. Local anesthesia, sterilization, and supplies billed as separate charges (these services and items are included in allowance for procedure)

8. Materials not approved by the American Dental Association
9. Prescription drugs, medications, or supplies
10. Services for Temporomandibular Joint Disorder.
11. Services to the extent that they are not recommended and approved by the licensed Dentist attending the Insured Person, charges above the Usual and Customary Expenses as determined by the Company; charges for failure to keep scheduled appointments, or for filling out claim forms
12. Study and diagnostic models

VISION BENEFIT

Under the vision benefit, you can receive services from any licensed provider. Your provider may bill you for any amounts charged over the dollar maximums listed below. These services are not subject to the \$75 quarterly deductible and this Plan will pay the following:

Covered Benefits	Limitations
Eye Exam	Covered at 100% up to a maximum of \$75 per policy year
Hardware (includes frames, lenses, contacts)	Covered at 100% up to a maximum of \$200 per policy year

DEFINITIONS

Coinsurance

The percentage of Expenses for which the Insured Person is responsible for a covered service.

Copayment

The specified dollar amount an Insured Person must pay for specified charges. The Copayment is separate from and not a part of the Deductible or Coinsurance.

Covered Charge or Covered Medical Expense

Reasonable charges which are:

- (a) not in excess of Usual and Customary Charges;
- (b) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits
- (c) made for services and supplies not excluded under the policy;
- (d) made for services and supplies which are a Medical Necessity;
- (e) made for services included in the Schedule of Benefits; and
- (f) in excess of the amount stated as a Deductible, if any.

Covered Medical Expenses will be deemed "incurred" only:

- (a) when the covered services are provided; and
- (b) when a charge is made to the Insured Person for such services.

Covered Percentage

That part of the Covered Charge that is payable by the Company after the Deductible or Copayment has been met.

Deductible

If an amount is stated in the Schedule of Benefits or any endorsement to this policy as a Deductible, it shall mean an amount to be subtracted from the amount or amounts otherwise payable as Covered Medical Expenses before payment of any benefit is made.

The Deductible will apply per quarter as specified in the Schedule of Benefits.

Domestic Partner

The same-sex partner of an Insured Student who:

- (a) has submitted a copy of the City of Seattle Domestic Partnership Certificate or Certificate from other jurisdictions where Domestic Partner registration is offered;
- (b) is considered the Insured Student's "sole Domestic Partner";
- (c) is, along with the Insured Student, at least 18 years of age;
- (d) is, along with the Insured Student, jointly responsible for each other's welfare and financial obligations; and
- (e) is, along with the Insured Student, not married or related by blood.

Hospital

A licensed or properly accredited general hospital which:

- (a) is open at all times;
- (b) is operated primarily and continuously for the treatment of and surgery for sick and injured persons as inpatients;
- (c) is under the supervision of a staff of one or more legally qualified Physicians available at all times;
- (d) continuously provides on the premises 24 hour nursing service by Registered Nurses;
- (e) provides organized facilities for diagnosis and major surgery on the premises; and
- (f) is not primarily a clinic, nursing, rest or convalescent home, or an institution specializing in or primarily treating Mental and Nervous Disorder.

Injury

A Bodily injury which is:

- (a) directly and independently caused by specific accidental contact with another body or object;
- (b) unrelated to any pathological, functional, or structural disorder;
- (c) a source of loss;
- (d) treated by a Physician within one year after the date of accident; and
- (e) sustained while the Insured Person is covered under this policy.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity.

Insured Student

A student of the Seattle Campus of the University of Washington who is eligible and insured for coverage under this Plan.

Insured Person

An Insured Student and his or her covered Dependent(s) while insured under this Plan.

International Student

A student classified as a Non-Immigrant. For example, students holding visa types: "F" (Student), "J" (Exchange Visitor), "B" (Tourist), or "A" (Diplomat).

Loss

A medical expense covered by this Plan as a result of Injury or Sickness as defined in this Plan.

Medical Emergency

A sudden, serious and unexpected injury or sickness that, without immediate medical attention, a reasonable person would believe could result in:

- (a) death;
- (b) jeopardy to personal health;
- (c) jeopardy to the health of a fetus, in the case of a pregnant woman;
- (d) serious dysfunction of any body organ or part;
- (e) serious impairment of bodily functions.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or Sicknesses.

Medically Necessary

Those services or supplies provided or prescribed by a Hospital or Physician which are:

- (a) essential for the symptoms and diagnosis or treatment of the Sickness or Injury;
- (b) provided for the diagnosis or the direct care and treatment of the Sickness or Injury;
- (c) in accordance with the standards of good medical practice;
- (d) not primarily for the convenience of the Insured or the Insured's Physician; and
- (e) the most appropriate supply or level of service which can safely be provided to the Insured.

The Medical Necessity of being Hospital confined means that:

- (a) the Insured requires acute care as a bed patient; and
- (b) the Insured cannot receive safe and adequate care as an outpatient.

This policy only provides payment for services, procedures and supplies which in the judgement of the Company are a Medical Necessity. No benefits will be paid for expenses which are determined not to be a Medical Necessity, including any or all days of Hospital Confinement.

Network Providers

Physicians, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

Non-Network Providers

Physicians, Hospitals and other healthcare providers who have not agreed to any pre-arranged fee schedules.

Per Condition Aggregate Maximum

The total amount of benefits payable for each Injury or Sickness under the Student Health Insurance Policy.

Physician

A legally qualified licensed practitioner of the healing arts who provides care within the scope of his/her license, other than a member of the person's immediate family. The term "member of the immediate family" means any person related to an Insured Person's within the third degree by the laws of consanguinity or affinity.

Physiotherapy

Means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

Preferred Allowance

The amount a Network Provider will accept as payment in full for Covered Medical Expenses.

Policy Year

The 12-month period beginning and ending on the Effective Dates of the Policy.

Sickness

A sickness or disease of the Insured Person which causes loss, and originates while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one sickness.

Usual and Customary Charges/Usual and Customary Expenses

A reasonable charge which is:

- (a) usual and customary when compared with the charges made for similar services and supplies; and
- (b) made to persons having similar medical conditions in the locality of the Policyholder.

No payment will be made under this policy for any expenses incurred which in the judgement of the Company are in excess of Usual and Customary Charges.

We, Us, Our, the Company

The MEGA Life and Health Insurance Company

You, Your or Yours

The Insured Person.

CLAIM FILING INFORMATION

In the Service Area

Be sure to present one of the following to your provider when receiving treatment:

- Your identification card, (found on the front flyleaf of this brochure)
- A claim form (available at Hall Health Primary Care Center or at <http://depts.washington.edu/ovpsa/insurance.html>)
- Your student identification number, Social Security Number, and Policy Number.

Filing of claims for services is not necessary at UW Medical Center, Harborview, UW Physicians, and University Physicians Network providers. If you receive a bill from these providers, please verify with them that they have billed WPAS.

Hall Health

If you were treated at Hall Health Primary Care Center:

- HHPCC will submit your claim directly for you if you have provided the billing office with the current necessary information
- If you have had a change in your status, you must contact the HHPCC's Billing Office (206-616-1881)
- You must take the appropriate steps to clarify or provide additional information to either the HHPCC or WPAS when requested
- If your claim is denied or rejected, you are financially responsible for the amount charged for any services provided to you
- Payment will be made directly to the HHPCC. You will be issued a separate bill for any amounts denied, rejected or otherwise not covered.

How to Submit Other Claims

When a provider or Hospital does not bill WPAS directly, you must submit your own claims. Send the itemized bill and claim form to WPAS at the address below.

CLAIMS SUBMISSION DEADLINE

Claims must be submitted within 120 days. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event later than one year.

For questions regarding your claim or benefits, contact:

UW/WPAS Claims Office

P.O. Box 34600

Seattle, WA 98124-1600

206-374-9439 (local) OR

1-866-535-8503 (toll-free)

e-mail: studentinsurance@wpas-inc.com

REVIEW OF COMPLAINTS & REJECTED CLAIMS

If an Insured Person has a complaint against the Company or if the Company has notified an Insured Person in writing that a claim has been denied, the Insured Person or his or her authorized representative may request a review of the claim or complaint against the Company by applying in writing within 90 days after receiving notice of the rejection or the action which lead to the complaint. The Insured Person or his or her representative may review pertinent documents at the Company. The Company will review the appeal and notify the Insured Person in writing of the decision within 30 days, unless special circumstances result in a delay. In any event, the Insured Person will be notified as soon as possible and not later than 60 days after the request for the review (except for claims denied as investigational). In the case of a claim being denied as investigational, the Company will notify the Insured Person in writing within 20 working days following receipt of a fully documented claim; an extension of deadline will require the Insured Person's written consent.

APPEAL TO ARBITRATION

If an Insured Person is dissatisfied with the final written decision of the Company, he or she has the right to submit the matter to arbitration in accordance with the American Arbitration Association, provided he or she submits a request for arbitration to the UW/WPAS claims office, in writing, within sixty (60) days of receipt of the final decision. The Insured's costs associated with the Appeal to Arbitration are the responsibility of the Insured Person.

Subrogation and Recovery Rights

Right to Subrogation: The Company shall be subrogated to all rights of recovery which any Insured Person has against any person, firm or corporation to the extent of payments for Benefits made by the Company to or for benefits of an Insured Person. The Insured shall execute and deliver such instruments and papers as may be required and do whatever else is necessary to secure such rights to the Company. The Company shall recover only that portion paid by the Company which is in excess of the amount necessary to fully compensate the Insured for all expenses incurred as a result of his/her loss. The Insured shall be permitted to recoup his/her general damages which is not limited to medical expenses, from the tort-feasor before subrogation provided that in so doing, the Insured does not prejudice the rights of the Company.

Right of Recovery: Payments made by the Company which exceed the Covered Medical Expenses (after allowance for Deductible and coinsurance clauses, if any) payable hereunder shall be recoverable by the Company from or among any persons, firms or corporations to or for whom such payments were made or from any insurance organizations who are obligated in respect of any covered Injury or Sickness as their liability may appear.

Excess Provision

No benefit under this policy is payable for any Expense incurred for Injury or Sickness which is paid or payable by: (1) other valid and collectible insurance or (2) under an automobile insurance policy. This Excess Provision will not be applied to the first \$500.00 of Covered Medical Expenses incurred. Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

WHEN YOU ARE NO LONGER ELIGIBLE

The benefits under this Plan end at the conclusion of the term for which you purchased it. See "Effective Dates" section for the termination dates for each quarter. There is no extension of coverage beyond the date for which you purchased coverage, except if you continue to qualify as a student, in which case you would need to re-enroll in a timely manner. See the "Eligibility" and "Enrollment" sections.

Extension of Benefits After Termination

The coverage provided under this policy ceases on the termination date. However, if an Insured is hospital confined on the termination date from a covered injury for which benefits were paid before the termination date, covered medical expenses for such injury will continue to be paid as long as the condition continues but not to exceed 365 days after the termination date. The total payments made in respect of the Insured for such condition both before and after the termination date will never exceed the maximum benefit.

HALL HEALTH PRIMARY CARE CENTER

(University of Washington Student Health Service)

Hall Health Primary Care Center (HHPCC) provides outpatient health and medical care for all currently enrolled students and their Dependents. While it is not necessary to purchase this Plan in order to use HHPCC, students are encouraged to enroll in the Plan to cover those costs and to defray expenses when outside medical care, hospitalization or lab work is needed.

Hall Health Primary Care Center services are provided by highly trained and experienced professional staff. HHPCC is committed to providing you with the best outpatient health care service available.

Administrative Services

General Information	206-685-1011
Registration & Appointments	206-616-2495
Administration	206-685-1081
Business & Insurance	206-616-1881

Clinical Services

Consulting Nurse	206-221-2517
Health Education & Nutrition	206-616-8476
Mental Health Clinic	206-543-5030
Pharmacy	206-685-1021
Sports Medicine	206-685-1044
Travel Medicine	206-685-1060
Women's Clinic	206-685-1031

An Internet home page for additional information regarding HHPCC is located at www.hallhealthcenter.com.

HHPCC is open Monday through Friday from 8:00 a.m. to 5:00 p.m., except Tuesdays when they are open from 9:00 a.m. to 5:00 p.m. They are closed on Saturdays, Sundays and holidays.

**A detailed brochure describing the services of
Hall Health Primary Care Center is available at the Center.
It is the patient's responsibility to keep HHPCC informed
of his/her insurance status.**