THE JOHNS HOPKINS UNIVERSITY
STUDENT HEALTH BENEFITS PLAN

Effective August 15, 2016

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TABLE OF CONTENTS

ARTICLE 1: DEFINITIONS

ARTICLE 2: ELIGIBILITY AND PARTICIPATION

ARTICLE 3: BENEFITS

ARTICLE 4: HEALTH INFORMATION PRIVACY AND SECURITY

ARTICLE 5: ADMINISTRATION

ARTICLE 6: CLAIMS AND APPEAL PROCEDURES

ARTICLE 7: AMENDMENT OR TERMINATION OF PLAN

ARTICLE 8: GENERAL PROVISIONS

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PREAMBLE

This amended and restated Johns Hopkins University Student Health Benefits Plan is effective August 15, 2016

The purpose of the Plan is to provide health benefits to Students of the Johns Hopkins University ("JHU") and their eligible Dependents.

This Plan is intended to be a self-funded student health plan exempt from the requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and the Maryland Insurance Code, except as required by HB 1247, enacted on April 26, 2016.

GENERAL INFORMATION

PLAN NAME:	The Johns Hopkins University Student Health Benefits Plan (Plan or SHBP)
EFFECTIVE DATE:	August 15, 2016 *Carey Business School has Early Arrivals effective in July each year.
PLAN SPONSOR:	The Johns Hopkins University 3400 N. Charles Street Baltimore, MD 21218
GROUP NUMBER:	ST0858SH
PLAN ADMINISTRATOR:	The Johns Hopkins University
CLAIM ADMINISTRATOR:	Wellfleet 2077 Roosevelt Avenue Springfield, MA 01104 877-657-5044 www.wellfleetstudent.com
IN-NETWORK PROVIDERS:	Cigna PPO Network of Participating Providers www.cigna.com (877) 657-5044 Prescription Benefits Administrator: Cigna Pharmacy Plan www.cigna.com (877) 657-5044

CASE MANAGEMENT SERVICES:	Hines and Associates (800) 670-7718
MEDICAL EVACUATION AND REPATRIATION PROVIDER:	Travel Guard General Inquiries: (877) 657-5030 North America: (877) 305-1966 Foreign County: (715) 295-9311

ARTICLE 1: DEFINITIONS

The following terms have the meanings indicated unless the context clearly requires otherwise:

1.1 ADMINISTRATOR means the Johns Hopkins University or agent appointed by the Johns Hopkins University in Article 5.

1.2 BENEFITS means reimbursements for certain health coverage described in Article 3.

1.3 DEPENDENT means a Student Participant's Spouse, Domestic Partner or a Child of the Student Participant.

1.4 CHILD means and is limited to: (i) a Student Participant's step-child, biological child or legally adopted child who is under age 26 or (ii) a Student Participant's unmarried step-child, biological child or legally adopted child who is age 26 or older and is permanently and totally disabled under Internal Revenue Code Section 22(e)(B) or (iii) any person under age 26 for whom the Student Participant must provide coverage under a child support order or any person who resides with the Student Participant for more than half the taxable year and for whom the Student Participant is appointed legal guardian by a court of competent jurisdiction or (iv) any child of the Student Participant's Domestic Partner who would otherwise qualify as a Child of the Student Participant under this section if the Domestic Partner and the Student were legally married to each other; provided, however, that the Child must reside with the Student Participant or Domestic Partner Participant.

1.5 DOMESTIC PARTNER means a person for whom a Student Participant filed a completed "Declaration of Domestic Partnership" with the Administrator but only for as long as he or she continues to qualify as the Student's Domestic Partner under the terms of that Declaration of Domestic Partnership and the Sponsor's Domestic Partner Policy (as determined by the Administrator).

1.6 EFFECTIVE DATE means August 15, 2016.

1.7 STUDENT means a person who is matriculated at the Johns Hopkins University.

The determination of an individual's status as a Student shall be made at the sole and absolute discretion of the Johns Hopkins University.

1.8 SPONSOR means the Johns Hopkins University, any successor or assign and any school within the Johns Hopkins University, such as the School of Medicine.

1.9 PARTICIPANT means a Student or Dependent covered by the Plan pursuant to Article 2.

1.10 PLAN means the Johns Hopkins University Student Health Benefits Plan.

1.11 PLAN YEAR means the twelve month period beginning each January 1 and ending each December 31 while this Plan is in effect.

1.12 SPOUSE means a Student's legal spouse under federal law.

ARTICLE 2: ELIGIBILITY AND PARTICIPATION

2.1 PARTICIPATION. All Students are eligible to participate in the Plan and automatically enrolled in the Plan unless the Student completes and files a Waiver Form with the Administrator on or before September 15th for the applicable Fall Semester (September 30th for Carey Business School, Peabody and SAIS (Bologna) students) or February 15th for the applicable Spring Semester.

2.2 TERMINATION OF PARTICIPATION. Except as otherwise expressly provided in this Section 2.2, a Student's participation in the Plan shall terminate as of the earliest of the following dates:

a. The last day of the coverage period for which the Student paid the required premium; or
b. The day of the Student's withdrawal from JHU;

Except as otherwise expressly provided in this Section 2.2, a Dependent's participation in the Plan shall terminate as of the earliest of the following dates:

a. The day the Student's coverage ends for any reason; or
b. The day the Dependent ceases to be an eligible Dependent for any reason.

If a Student withdraws from JHU within the first 31 days of becoming a Participant in the Plan (other than a withdrawal relating to an accident or illness covered by the Plan), he or she will receive a full refund of the premium paid less any expenditures made by the Plan on his or her behalf (or on behalf of his or her Dependent). Thereafter, no refunds will be issued and coverage will continue for the period for which premiums were paid; provided, however, that upon a Participant's withdrawal from JHU because of entry into the armed services of any country, his or her participation in the Plan shall cease and the Administrator shall issue a pro-rata refund of premiums paid upon the Participant's written request, which must be made to the Administrator no later than 90 days after withdrawal from JHU.

In addition, a Participant's participation in the Plan shall terminate on the day on which all Benefits are terminated by amendment of the Plan, by whole or partial termination of the Plan or by discontinuation of contributions by the Sponsor, as described in Article 7.

In the event a Participant is permanently and totally disabled (as defined by Internal Revenue Code Section 22(e)(B)) on the date coverage otherwise would terminate, the Participant will continue to be covered under the Plan until the earlier of the one year anniversary of the date coverage otherwise would have terminated or the date the Participant is no longer permanently and totally disabled (subject to the Sponsor's rights to amend or terminate the Plan as provided in this Plan).

In the event a Participant is hospitalized due to an Injury or Sickness Covered by the Plan on the date coverage otherwise would terminate, the Participant will continue to be covered under the Plan until the earlier of the one year anniversary of the date coverage otherwise would have terminated or the date the Participant is discharged from the hospital (subject to the Sponsor's rights to amend or terminate the Plan as provided in this Plan).

In the event a Student has a new baby, adopts a Child, or a Child is placed with the

Student for adoption, and the Student enrolls the new Dependent within 30 days of such event, the Child's coverage becomes effective on the date of the birth or adoption or placement for adoption. If not, the new Child's coverage will automatically terminate on the 31st day after such event.

2.3 CHANGING COVERAGE. Participants may change coverage at any time for any reason, subject to any restrictions by the Plan Sponsor, by submitting the appropriate form to the Plan Administrator.

2.4 LATE ENROLLMENT.

(a). Losing Other Coverage. A Student who does not enroll in this Plan because he or she had coverage through another source (such as a Spouse's employer or COBRA), and who subsequently loses that coverage, may enroll in this Plan by submitting a properly completed enrollment form within 30 days of losing other coverage. If the completed form is received within 30 days of losing other coverage, Plan coverage will be effective on the date the prior coverage ends with no waiting period.

This enrollment right does not apply if coverage under the other plan terminated for failure to make required contributions or for cause (such as making a fraudulent claim).

(b). New Children. Children acquired through birth, adoption, or placement for adoption, may enroll by submitting a properly completed enrollment form within 30 days following the date the Child is acquired. If enrolled within 30 days following the date the Child is acquired, coverage will become effective on the date of the birth, adoption, or placement for adoption. The Student must also be enrolled in coverage to enroll a newly acquired Child. The Student's Spouse, Domestic Partner and any other Children may also enroll in coverage at such time.

(c). Medicaid and Children's Health Insurance Program. A Student or Child of a Student with health insurance coverage under Medicaid or a Children's Health Insurance Program ("CHIP") that loses eligibility for that coverage may enroll in this Plan by submitting a properly completed enrollment form within 60 days of losing Medicaid or CHIP coverage. If a properly completed enrollment form is submitted within 60 days of losing Medicaid or CHIP coverage, coverage will become effective on the first day of the month after submitting the enrollment form.

A Student or Child of a Student that becomes eligible to receive assistance from Medicaid or CHIP to pay required contributions for coverage under this Plan , may still enroll for coverage under this Plan by submitting a properly completed enrollment form within 60 days of becoming eligible for the assistance. If a properly completed enrollment form is submitted within 60 days of becoming eligible for the assistance, coverage under the Student Health Program will become effective on the first day of the month following the date the enrollment form is submitted.

(d). Medical Leaves of Absence. Coverage will continue under the Plan for covered Students who take an approved leave of absence on or after the first day of fall or spring classes until the first to occur of: (a) the last day of the coverage period for which the required premium was paid; or (b) the last day of the Plan Year. Thereafter, Students that remain on an approved leave of absence following the first to occur of: (a) the last day of the coverage period for which the required premium was paid; or (b) the last day of the Plan Year, may

purchase additional Plan coverage for up to 3 months at the medical leave of absence rate then in effect.

ARTICLE 3: BENEFITS

3.1 BENEFITS. Benefits under this Plan are limited to the benefits set forth on Schedule A, "Schedule of Benefits and Exclusions."

3.2 BENEFITS FROM ANOTHER SOURCE. Reimbursement under this Plan shall be made only in the event and to the extent that reimbursement has not been provided under any other insurance policy or under another plan of the Sponsor or under any federal or state law or reimbursed from any other source. In the event that there is such a policy, plan or law in effect providing for such reimbursement or payment in whole or in part, then to the extent of the coverage under such policy, plan or law, the Sponsor shall be relieved of any and all liability hereunder.

ARTICLE 4: HEALTH INFORMATION PRIVACY AND SECURITY

4.1 SCOPE OF ARTICLE. This Article 4 is intended to provide for the Plan's compliance with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 and published as the "Standards for Privacy of Individually Identifiable Health Information" (the Privacy Regulations) and the "Health Insurance Reform: Security Standards" (the Security Regulations) and other applicable guidance, as well as all applicable requirements of Subtitle D of the "Health Information Technology for Economic and Clinical Health Act" (the HITECH Act) and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan.

The Plan will comply with all applicable requirements of the Privacy Regulations, the Security Regulations and Subtitle D of the HITECH Act, as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Privacy and Security Regulations or Subtitle D of the HITECH Act and any provision of this Plan, applicable law will control. Also, any amendment or revision or authoritative guidance relating to the Privacy and Security Regulations or of Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with that guidance.

4.2 PROTECTED HEALTH INFORMATION. For purposes of the Plan, "Protected Health Information" has the same meaning as provided for that term in the Privacy Regulations and is limited to information that is Protected Health Information with respect to the Plan.

4.3 DISCLOSURES TO SPONSOR. The Plan will disclose Protected Health Information to Sponsor only as follows:

(a). Summary Health Information. The Plan may disclose Protected Health Information that is summary health information (as defined in §164.504(a) of the Privacy Regulations) to the Sponsor, if the Sponsor requests the summary health information for the purpose of:

(i) Obtaining premium bids from stop-loss carriers or excess loss carriers for providing stop-loss or excess loss coverage under the Plan; or

(ii) Modifying, amending or terminating the Plan.

(b). Enrollment Information. The Plan may disclose to the Sponsor information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health option offered by the Plan.

(c). Other Disclosures to the Sponsor. Except as provided in Sections 7.3(a) and 7.3(b), or under the terms of an applicable individual authorization, the Plan may disclose Protected Health Information to the Sponsor and may permit the disclosure of Protected Health Information with respect to the Plan to the Sponsor only if the Sponsor requires the Protected Health Information to administer the Plan. The Sponsor, by signing this Plan document, certifies that it:

(i) will not use or further disclose Protected Health Information other than as permitted by the Plan or as required by law;

(ii) will ensure that any agents to whom it provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Sponsor with respect to such information;

(iii) will not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Sponsor;

(iv) will report to the Plan any use or disclosure, of which it becomes aware, of Protected Health Information that is inconsistent with the uses or disclosures permitted under the Plan;

(v) will make Protected Health Information available to the individual who is the subject of that information in accordance with §164.524 of the Privacy Regulations;

(vi) will consider requested amendments to an individual's Protected Health Information in accordance with §164.526 of the Privacy Regulations;

(vii) will make available the information required to provide an accounting of disclosures of Protected Health Information in accordance with §164.528 of the Privacy Regulations;

(viii) will make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Regulations;

(ix) if feasible, will return or destroy all Protected Health Information received from the Plan that the Sponsor still maintains in any form and will retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if return or destruction is not feasible, the Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

(x) will ensure that the adequate separation of the Plan and the Sponsor as required in this Article is established.

(d). Prohibited Disclosures. The Plan will not disclose Protected Health Information to the Sponsor for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Sponsor.

4.4 SEPARATION OF HEALTH PLAN AND THE SPONSOR. The Sponsor has designated and trained certain employees to be the only employees of the Sponsor who will have access to Protected Health Information on behalf of the Plan. Those employees are identified on the attached Schedule B. If there are any changes to the group of employees who are authorized to have access to Protected Health Information on behalf of the Plan, Schedule A will be revised to reflect those changes. Any revised Schedule B is incorporated into the Plan as of the effective date of the revision without the need for further amendment to the Plan. Except as otherwise permitted under applicable law and this Plan, employees listed on Schedule B will use or disclose Protected Health Information only to the extent appropriate for performing administrative services that the JHU provides for the Plan.

The Sponsor will work with the Plan's designated Privacy Official to establish effective policies and procedures for identifying, investigating, remedying and disciplining any alleged instances of noncompliance with the requirement that employees of the Sponsor who have access to Protected Health Information use that Protected Health Information only for the purposes specified in this Article.

4.5 PRIVACY NOTICE. The Plan will comply with the applicable requirements of the Privacy Notice issued by the Plan pursuant to the requirements of the Privacy Regulations and the Plan's Privacy Notice is incorporated into the Plan by this reference. If the Privacy Notice is revised, the Plan will comply with the revised Privacy Notice as of the effective date of the revision. A revised Privacy Notice is incorporated into the Plan as of the effective date of each revision without the need for further amendment of the Plan.

4.6 SECURITY REGULATIONS. The Plan will comply with all applicable requirements of the Security Regulations, as provided in this Article and in the Security Regulations and as interpreted pursuant to any authoritative guidance issued by the Department of Health and Human Services. If there is any conflict between the requirements of the Security Regulations and any provision of this Plan, the Security Regulations will control. Also, any amendment or revision or authoritative interpretation of the Security Regulations is incorporated into the Plan on the effective date of that guidance.

In addition, the Sponsor, by adopting this document, will

(a). Reasonably and appropriately safeguard electronic Protected Health Information created, received, maintained, or transmitted to or by the Sponsor on behalf of the Plan;

(b). Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

(c). Ensure that the adequate separation required by §164.504(f)(2)(iii) of the Privacy Regulations is supported by reasonable and appropriate security measures;

(d). 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 that information; and

(e). Report to the Plan any security incident of which it becomes aware.

4.7 BREACH REPORTING. The Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

ARTICLE 5: ADMINISTRATION

5.1 THE ADMINISTRATOR. Except as to those functions reserved within the Plan to the Sponsor, the Administrator shall control and manage the operation and administration of the Plan.

5.2 ADMINISTRATIVE RULES AND DETERMINATIONS. Subject to the limitations of the Plan, the Administrator shall establish rules for the administration of the Plan and the transaction of its business. The Administrator shall have the exclusive right (except as to matters reserved to the Sponsor), to interpret the Plan and to decide all matters arising thereunder, including the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Administrator or the Sponsor in respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following powers and duties:

(a) To require any person to furnish such information, including, but not limited to, the execution of any agreements, as the Administrator may request for the purpose of the proper administration of the Plan as a condition to receiving any Benefits under the Plan;

(b) To make and enforce such rules and regulations as the Administrator shall deem necessary for the efficient administration of the Plan;

(c) To prescribe the use of such forms as the Administrator shall deem necessary for the efficient administration of the Plan;

(d) To decide on questions concerning the Plan and the eligibility of individual to participate in the Plan, in accordance with the provisions of the Plan; and

(e) To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, to inform the Sponsor of the amount of such Benefits and to provide a full and fair review to any individual whose claim for Benefits has been denied in whole or in part.

In carrying out its duties herein, the Administrator shall have discretionary authority to exercise all powers and to make all determinations, consistent with the terms of the Plan, in all matters entrusted to it, and its determinations shall be given deference and shall be final and binding on all interested parties.

5.3 DELEGATION AND RELIANCE. The Administrator, subject to approval of the Sponsor, may employ the services of such firms or persons as it may deem necessary or desirable in connection with the Plan. The Administrator may delegate any of its powers or duties to another person or persons. The Administrator and the Sponsor (and any person to whom the Administrator may delegate any duty or power in connection with the administration of the Plan) and all persons connected therewith may rely upon all tables, valuations, certificates, reports and opinions furnished by any duly appointed actuary, accountant (including employees of the Sponsor who are actuaries or accountants) or legal counsel, or other specialist, and they shall be fully protected in respect to any action taken or permitted in good faith in reliance thereon. All actions so taken or permitted shall be conclusive upon all persons.

5.4 INDEMNIFICATION AND INSURANCE. To the extent permitted by law, neither the Administrator, nor any other person performing duties hereunder, shall incur any liability for any act done, determination made or failure to act, if in good faith, and the Sponsor shall indemnify the Administrator, its members and such other persons against any and all liability which is incurred as a result of the good faith performance or non-performance of their duties hereunder. Nothing in this Plan shall preclude the Sponsor from purchasing liability insurance to protect such persons with respect to their duties under this Plan.

5.5 COMPENSATION, EXPENSES AND BOND. Unless otherwise agreed to by the Sponsor, the Administrator shall serve without compensation for its services as such, but all reasonable expenses incurred in the performance of its duties shall be paid by the Sponsor. Unless otherwise determined by the Sponsor or unless required by any federal or state law, the Administrator shall not be required to give any bond or other security in any jurisdiction.

5.6 ADMINISTRATIVE EXPENSES PAID BY SPONSOR. All administrative expenses incurred in connection with the Plan, including but not limited to administrative expenses and compensation and other expenses and charges of any actuary, counsel, accountant, specialist or other person who shall be employed by the Administrator in connection with the Plan, shall be paid by the Sponsor.

ARTICLE 6: CLAIMS AND APPEAL PROCEDURES

6.1 CLAIMS. Notwithstanding any provision of this Plan to the contrary, claims filed prior to July 1, 2016 shall be governed by the terms of the Plan then in effect. Claims filed on or after July 1, 2016 shall be governed by the terms set forth herein.

To receive benefits under the Plan, the Participant must file a claim with the Sponsor's designated agent to accept claims (currently, Cigna).

A "claim" is a request for coverage of treatment already received or a request for preauthorization of coverage for treatment the Participant would like to receive. A decision by a provider that the Participant does not need a certain treatment is not a "claim." The Plan's procedures do not apply until a "claim" is filed.

The Plan's procedures also apply to a determination by JHU or the Claim Administrator (currently, Wellfleet) that a Student or Dependent is not covered under the Plan. Students covered by the Plan that are determined to be no longer eligible for coverage for a reason other than failure to maintain enrollment or pay the required contribution (a "Rescission Determination"), will remain covered until their rights have been exhausted under these procedures.

The Sponsor's designated agent to administer claims and appeals, the "Claim Administrator" is responsible for investigating and adjudicating all claims hereunder and has authority to determine the amount of benefits that will be paid and to make final decisions on claims and appeals.

6.2 FILING A CLAIM. The requirements to file a claim differ depending on whether the claim is an "Urgent Care Claim," a "Pre-Service Claim" or a "Post-Service Claim" and there are special rules if pre-approved courses of treatment are reduced or terminated, or to extend a pre-approved course of treatment.

The Participant, Participant's Authorized Representative or health care provider may file a claim, appeal a denial of benefits, or file a Complaint with the Maryland Insurance Commissioner.

To name an Authorized Representative, the Participant must complete a Designation of Authorized Representative form, which may be obtained from the Claim Administrator.

To file a claim, the Participant, Authorized Representative or health care provider must complete and submit a claim form to Cigna. Claims should be submitted promptly.

No claims will be accepted more than 12 months after the treatment was provided.

(a) Urgent Care Claims. An Urgent Care Claim is a service or supply that must be preauthorized and is needed for Urgent Care. A service or supply is for Urgent Care if, following the time limits set forth below for Pre-Service Claims in the *"Claims Decisions"* section of this Summary, failure to provide the service or supply:

(i) could seriously jeopardize your or your Dependent's life, health or ability to regain maximum function;

(ii) in the opinion of a physician with knowledge of your or your Dependent's medical condition, would subject you or your Dependent to severe pain that cannot be adequately managed without the service or supply; or

(iii) could cause you or your Dependent to be a danger to yourself or others.

In general, CIGNA will determine whether a service or supply is for Urgent Care, however, if a physician with knowledge of the patient's medical condition determines that the service or supply is for Urgent Care, CIGNA will defer to the physician's determination.

(b). Pre-Service Claims. A "Pre-Service Claim" means a service or supply that must be preauthorized in order to be covered or to avoid a penalty.

If the Participant is preauthorized for a specific period or number of treatments and later it is determined that the preauthorized period or number of treatments should be reduced or terminated, the Participant will be notified in advance and provided time to file an appeal and receive a determination before the reduction or termination takes effect. The Participant must submit his or her appeal in accordance with Sections 6.4 and 6.5 hereunder.

If a course of treatment is preauthorized, the Plan may not deny reimbursement to the provider for the preauthorized treatment delivered to the patient unless:

- The information submitted regarding the treatment was fraudulent or intentionally misrepresentative;
- Critical information required was omitted such that the determination made would have been different had the critical information been known prior to the decision;
- The preauthorized course of treatment for the patient was not substantially followed by the Health Care provider; or
- On the date the preauthorized treatment was delivered:
    - the patient was not covered by the Plan;
    - The Claim Administrator maintained an automated eligibility verification system that was available to the Health Care provider by telephone or via the Internet; and
    - according to the verification system, the patient was not covered by the Plan.

To extend the period or number of preauthorized treatments, the Participant or health care provider must file a request to extend the approved course of treatment. A request that is filed before the additional treatment is provided is a Pre-Service Claim. A request that is filed after the additional treatment is provided is a Post-Service Claim. The Participant must submit his or her claim in accordance with this Section 6.2.

(c). Post-Service Claims. A "Post-Service Claim" means a service or supply that does **not** need to be preauthorized.

Itemized bills must include the following information:

- the date(s) the services, drugs or supplies were received;
- the diagnosis;
- a description of the treatment received;
- the charge for each service, drug or supply;
- the name, address and professional status of the provider;
- proof of payment (e.g., cancelled check, credit/debit card receipt); and
- the full name of the patient.

(d). Rescission Determinations. A "Rescission Determination" means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to pay required premiums or contributions towards the cost of coverage. The Plan will provide 30 days advance written notice of any proposed Rescission of coverage.

6.3 CLAIMS DECISIONS**.** All notices of claim decisions will be written in a manner calculated to be easily understood and will be provided in a culturally and linguistically appropriate manner. Notices will include a description of the right to file a Complaint with the Maryland Insurance Commissioner. Once a claim has been properly filed and the Claim Administrator has all of the necessary information, the claim will be processed as set forth below.

(a) Urgent Care Claims. Unless additional information is needed, the Claim Administrator will notify whoever filed the claim (referred to as the "Claimant"), of an Urgent Care Claim decision within 24 hours after the claim is properly filed. If an Urgent Care Claim

involves a request to extend an approved course of treatment, and the request is received at least 24 hours before the end of the approved course of treatment, the Claim Administrator will notify the Claimant of the decision within 24 hours. The initial notice will be oral and within one day after the oral notice, the decision will be delivered in writing to the Claimant.

If additional information is needed to decide an Urgent Care Claim, the Claim Administrator will contact the Claimant by phone within 24 hours and told what additional information is needed and the Claimant will have 48 hours to supply it. The time limit to decide the Urgent Care Claim is suspended until the Claimant supplies the additional information. The Claimant will be notified of the Claim Administrator's decision on the Urgent Care Claim within 24 hours after the earlier of when (1) the Claimant supplies the additional information or (2) the time to supply the additional information expires.

If the Claimant does not supply the information within 48 hours, the claim will be processed without the additional information, a decision on the claim will be made taking into account all the information available and the Claim Administrator may draw reasonable presumptions from the failure to supply the additional information.

(b) Pre-Service Claims. If a Pre-Service Claim is improperly filed, the Claimant will be notified within five days. The notice may be oral, unless the Claimant requests that it be written.

Unless additional information is needed, the Claimant will be notified of a Pre-Service Claim decision within 15 days after the claim is properly filed, but not later than five days after the decision has been made. If there are matters beyond the Claim Administrator's control, this period may be extended up to 15 more days. If an extension is needed, the Claimant will be told before the initial 15 day period ends why an extension is needed and when a decision is expected.

If within three calendar days after receipt of the initial request for health care services, additional information is needed to decide a Claim, the Claimant will be contacted by phone and told what additional information is needed and will have 45 days to supply it. The time limit to decide the claim is suspended until the Claimant supplies the additional information. If the Claimant does not supply the information within 45 days, the claim will be processed without the additional information, a decision on the claim will be made taking into account all the information available and the Claim Administrator may draw reasonable presumptions from the failure to supply the additional information.

If prior authorization is required for an emergency inpatient admission, or an admission for residential crisis services for treatment of a mental, emotional or substance abuse disorder, CIGNA will make all determinations on whether to authorize or certify such an inpatient admission or admission for residential crisis services within two hours after receipt of the information necessary to make the determination, and will promptly notify the health care provider of the determination.

If a Pre-Service Claim decision involves an initial determination regarding nonemergency course of treatment, the decision will be made within two working days after receipt of the information necessary to make the decision, and your provider will be promptly notified of the decision.

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If a Pre-Service Claim decision involves an extended stay in a health care facility

or additional health care services, the decision will be made within one working day after receipt of the information necessary to make the decision, and your provider will be promptly notified of the decision.

(c) Post-Service Claims. If a Post-Service Claim is improperly filed, the Claimant will be notified within five working days. The notice may be oral, unless the Claimant requests that it be written.

Unless additional information is needed, if a Post-Service Claim is denied, the Claimant, his or her Authorized Representative or health care provider, will be notified, in writing, within 30 days after the claim is properly filed, but not later than five days after the decision has been made. If the Plan's determination cannot be made during this time period because of matters beyond the Claim Administrator's control, this period may be extended up to 15 more days. If an extension is needed, the Claimant will be told before the initial 30 day period ends why an extension is needed and when a decision is expected.

If additional information is needed to decide a Claim, the Claimant will be contacted by phone and told what additional information is needed and will have 45 days to supply it. The time limit to decide the claim is suspended until the Claimant supplies the additional information. If the Claimant does not supply the information within 45 days, the claim will be processed without the additional information, a decision on the claim will be made taking into account all the information available and the Claim Administrator may draw reasonable presumptions from the failure to supply the additional information.

(d) Notification of Decision. The Claimant will be notified both orally and in writing if any claim is denied in whole or in part. The Participant will also be notified both orally and in writing if he or she is the subject of a rescission determination. The notice will state why the claim was denied or coverage rescinded, the specific Plan provisions and factual basis on which the denial or rescission is based, any additional information that could change the decision and will state how and when the denial or rescission can be appealed.

The notice will state the name, business address and business telephone number of the designated employee or representative responsible for the claims decision processes. It will also state the internal rule or guideline relied on to deny the claim, if any, how to request a free copy of the rule or guideline, if any, and if the claim was denied because the treatment is not medically necessary or is experimental, how to request a free explanation of the scientific or clinical judgment relied upon.

The statement will reference the specific criteria and standards, including interpretative guidelines, on which the decision was based, and will not solely use generalized terms such as "experimental procedure not covered", "cosmetic procedure not covered," "service included under another procedure" or "not medically necessary."

With respect to a claim denied because the treatment is not medically necessary or is experimental, the health care professional will be (i) a licensed physician who is board certified or eligible in the same specialty as the treatment involved in the claim under review, or (ii) a panel of other appropriate health care service reviewers with at least one licensed physician on the panel who is board certified or eligible in the same specialty as the treatment involved in the claim under review. If the claim involves a mental health or substance abuse service, the health care professional will be (i) a licensed physician who (1) is board certified or eligible in the same specialty as the treatment involved in the claim under review, or (2) is actively

practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review, or (ii) a panel of other appropriate health care service reviewers with at least one licensed physician on the panel who (1) is board certified or eligible in the same specialty as the treatment involved in the claim under review, or (2) is actively practicing or has demonstrated expertise in the substance abuse or mental health service or treatment under review.

Urgent Care Claim notices will also explain the expedited review process.

If a claim is denied, the notice will set forth the Claimant's rights, which include the right to file a Complaint with the Maryland Insurance Commissioner within four months after receipt of a denial of an appeal and the right to file a Complaint with the Commissioner without completing the appeal process if the Complainant can demonstrate a compelling reason to do so, as determined by the Commissioner. The notice will include the Commissioner's address, phone number and fax number, a statement that the Health Education and Advocacy Unit is available to assist in both mediating and filing an appeal under the Plan's Claims and Appeals process, and the Health Education and Advocacy Unit's address, phone number, fax number and email address.

6.4 APPEALS**.** Notwithstanding any provision of this Plan to the contrary, appeals of claims filed prior to July 1, 2016 shall be governed by the terms of the Plan in effect before July 1, 2016. Appeals of claims filed on or after July 1, 2016 shall be governed by the terms set forth herein.

Claimants, their Authorized Representative or their provider may appeal an adverse claims decisions, reduction, termination or refusal to extend an approved course of treatment or rescission determination as set forth below.

6.5 FILING AN APPEAL. An appeal must be filed within 180 days after the Claimant, the Authorized Representative or the health care provider is notified that the claim has been denied. However, if notice is given of a proposed reduction or termination of an approved course of treatment and the Claimant, the Authorized Representative or the health care provider wish to appeal the proposed action and have a decision on the appeal before the proposed action takes effect, the appeal must be filed within 10 days after notice is given.

If an appeal is filed more than 10 days after notice is given of a proposed reduction or termination, the reduction or termination will probably take effect before a decision is made on the appeal.

If additional information is needed to decide a non-urgent care appeal, the Claims Administrator will notify the Claimant, the Authorized Representative or the health care provider within 5 working days after the appeal is filed what additional information is needed and assist with the collection of such information. The time to respond to a non-urgent care appeal may be extended only with the written consent of the Claimant, the Authorized Representative or the health care provider and such extension shall not exceed thirty (30) working days.

If additional information is needed to decide an Urgent Care Appeal, the Claim Administrator will notify the Claimant, the Authorized Representative or the health care provider by phone within 24 hours after the appeal is filed what additional information is needed and assist with the collection of such information. The Claimant, the Authorized Representative or the health care provider will have 48 hours to supply the additional information. The Claimant,

the Authorized Representative or the health care provider will be notified of the Claim Administrator's decision on the Urgent Care Appeal within 24 hours after the earlier of when (1) the additional information is suppled or (2) the time to supply the additional information expires.

If the additional information is not supplied within 48 hours, the appeal will be processed without the additional information, a decision on the appeal will be made taking into account all the information available and the Claim Administrator may draw reasonable presumptions from the failure to supply the additional information.

Note that the Claims Administrator cannot proceed with reviewing the appeal unless and until the additional requested information is provided.

If an appeal is not filed within the time frames set forth herein, the Claimant, the Authorized Representative and the Health Care provider lose all rights to appeal.

(a). Non-Urgent Care Appeals. Except for an appeal of a denial of an Urgent Care Claim, an appeal must be in writing and either hand delivered or mailed to the Claim Administrator. If mailed, a notice of receipt will be sent to the filer.

(b). Urgent Care Appeals. An appeal of a denial of an Urgent Care Claim may be made orally or in writing. All information relevant to an Urgent Care Claim appeal should be included with the appeal and supplied by telephone, fax, or hand delivered to the Claim Administrator.

(c). Appeals Process. The Claimant, the Authorized Representative or the health care provider may submit written comments, documents, records and other information relating to the claim. All information will be considered regardless of whether it was submitted or considered in the initial claim determination. Upon written request and free of charge, reasonable access will be provided to and copies allowed of all Plan documents, records and other information relevant to the appeal.

During the appeal process, the person filing the appeal will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by (or at the direction of) the Plan in connection with the appeal, and with any new or additional rationale for denying the claim. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the appeal will be decided, so as to give a reasonable opportunity to respond prior to that date.

If the denial of a claim involved a medical judgment (such as whether a treatment is experimental or medically necessary), a health care professional with training and experience in the field of medicine involved will review the appeal. If medical or vocational experts were consulted when a claim was denied, they will be identified upon request.

6.6 APPEAL DECISIONS. Appeals will be decided as follows:

(a) Urgent Care Claim Appeals. Unless additional information is needed, the Claim Administrator will notify the Claimant, the Authorized Representative or the health care provider of the decision on an Urgent Care Claim Appeal orally within 24 hours after the appeal is filed and in writing within one day of the oral notification.

(b) Post-Service Claim Appeals. Unless additional information is needed, the Claim Administrator will notify the Claimant, the Authorized Representative or the health care provider of the decision on a Post-Service Claim Appeal orally within 45 working days after the appeal is filed and in writing within 5 working days after oral notification.

(c) Pre-Service Claim Appeals. Unless additional information is needed, the Claim Administrator will notify the Claimant, the Authorized Representative or the health care provider of the decision on a Pre-Service Claim Appeal orally within 30 working days after the appeal is filed and in writing within 5 working days after oral notification.

(d) Reduction or Termination of an Approved Course of Treatment. Unless additional information is needed, the Claim Administrator will notify the Claimant, the Authorized Representative or the health care provider of the decision on an appeal of a reduction or termination of an approved course of treatment within 30 working days after the appeal is filed. However, if the appeal was filed within 10 days after notice of the proposed action was given, the course of treatment will not be reduced or terminated before the appeal is decided. (See below for additional Final Appeal rights that may apply before treatment is reduced or terminated.)

(e) Request to Extend an Approved Course of Treatment. If the appeal of a denial of a request to extend an approved course of treatment is filed before the additional treatment has been provided, the Pre-Service Claim time frame applies, unless the appeal involves Urgent Care, in which event the Urgent Care Claim time applies. If the appeal is filed after the additional treatment has been provided, the Post-Service Claim time applies.

(f) Notification of Decision. The person filing the appeal will be notified of the decision orally and in writing in accordance as set forth in (a) though (c) above. If the appeal is denied, the notice will state why, and will reference the specific Plan provisions and factual basis on which the denial is based. The notice will also state the internal rule or guideline relied on to deny the appeal, if any, how to request a free copy of the rule or guideline, if any, and if the claim was denied because the treatment is not medically necessary or is experimental, how to request a free explanation of the scientific or clinical judgment relied upon.

If the appeal is denied, the notice will state that the Claimant, his or her Authorized Representative or health care provider may file a complaint with the Maryland Insurance Commissioner as set forth below. The notice will include the Commissioner's address, phone number and fax number, a statement that the Health Education and Advocacy Unit is available to assist filing a complaint under the Plan's Appeals process, and the Health Education and Advocacy Unit's address. The notice will state the specific factual bases for the decision in clear, understandable language, reference specific criteria and standards, including interpretive guidelines, if any, on which the decision was based, state the name, business address, and business telephone number of the employee responsible for the Claims and Appeals processes.

6.7 COMPLAINTS TO THE COMMISSIONER. Within four months after receipt of an appeal decision (including a decision involving a Rescission Determination), the Claimant, Authorized Representative or health care provider may file a complaint with the Commissioner of the Maryland Insurance Administration for review of the appeal decision.

The Claimant, Authorized Representative or health care provider may file a complaint with the Commissioner before filing an appeal or receiving an appeal decision if:

(a) JHU waives the requirement that the internal Claims and Appeals process be exhausted before filing a complaint with the Commissioner;

(b) JHU or its agent(s) fail to comply with any of the requirements of the internal Claims and Appeals process;

(c) The Claimant, Authorized Representative or health care provider provides sufficient information and supporting documentation in the complaint to demonstrate a compelling reason to bypass the internal Claims and Appeals process, including, but not limited to, a delay in health care services, which could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the patient remaining seriously mentally ill with symptoms that cause the patient to be a danger to self or others;

(d) The complaint involves an Urgent Care Claim condition for which care has not been rendered; or

(e) The Claimant, Authorized Representative or health care provider do not receive the Plan's decision on an appeal within the applicable time frames:

(i) Within 30 working days after the filing date of an appeal regarding a Pre-Service Claim;

(ii) Within 45 working days after the filing date of an appeal regarding a Post-Service Claim;

(iii) Within 24 hours after the receipt of an appeal regarding an Urgent Care Claim.

ARTICLE 7: AMENDMENT OR TERMINATION OF PLAN

7.1 AMENDMENT. The Sponsor shall have the power at any time and from time to time, and retroactively if deemed necessary or appropriate, to modify or amend, in whole or in part, any or all of the provisions of the Plan in its sole discretion.

7.2 TERMINATION. The Sponsor shall have the power to discontinue or terminate the Plan at any time in its sole discretion.

7.3 REDUCTION OR TERMINATION OF BENEFITS. Participants in the Plan, have no right to Plan Benefits after a Plan termination or a partial Plan termination affecting them, and have no right to Plan Benefits to the extent that they are eliminated or reduced by a Plan amendment, except that such Participants are entitled to Benefits with respect to covered events giving rise to Benefits and occurring before the effective date of the Plan termination or applicable Plan amendment.

7.4 EFFECTIVE DATES. Any such amendment, discontinuance or termination shall be effective at such date as the Sponsor shall determine.

ARTICLE 8: GENERAL PROVISIONS

8.1 NO EMPLOYMENT CONTRACT. All Participants in this Plan are Students, or eligible Dependents of Students of the Johns Hopkins University. Nothing contained in this Plan

shall be construed as a contract of employment between any individual and the Johns Hopkins University.

8.2 APPLICABLE LAW. The provisions of the Plan shall be construed, administered and enforced according to applicable federal law, if any, and, where not preempted by federal law, the applicable laws of the State of Maryland required by HB 1247.

8.3 NON-ALIENATION PROVISIONS. No Benefit under the Plan is subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt to do so shall be void. No Benefit under the Plan is in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

8.4 PAYMENTS TO INCOMPETENTS. If the Administrator knows that any person entitled to payments under the Plan is incompetent by reason of physical or mental disability, age or some other cause, it may cause all payments thereafter becoming due to such person to be made to the person's legal guardian for the person's benefit, without responsibility to follow the application of amounts so paid. Payments made pursuant to this Section shall completely discharge the Administrator and the Sponsor.

8.5 INABILITY TO LOCATE RECIPIENT. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person (including a notice of the payment so due mailed to the last known address of such Participant or other person as shown on the records of the Sponsor), such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited 18 months after the date such payment first became due or after such period as is provided in the applicable insurance contract.

8.6 PLAN COMMUNICATIONS. All communications in connection with the Plan made by a Participant will become effective only when duly executed on forms provided by and filed with the Administrator.

8.7 SUBROGATION. As a condition to receiving medical, disability or any other benefits under the Plan, all Participants, including all covered Dependents, agree to transfer to the Plan their rights to make a claim, sue and recover damages when the injury or illness giving rise to the benefits occurs through the act or omission of another person. Alternatively, if a Participant receives any full or partial recovery, by way of judgment, settlement or otherwise, from another person, organization or business entity, the covered person agrees to reimburse the Plan, in first priority, for any medical, disability or any other benefits paid by it (i.e., the Plan shall be first reimbursed fully, to the extent of any and all benefits paid by it, from any monies received, with the balance, if any, retained by the Participant). The obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment or settlement, etc. specifically designates the recovery, or a portion thereof, as including medical, disability or other expenses. Furthermore, the obligation to reimburse the Plan, in full, in first priority, exists regardless of whether the judgment, settlement or other recovery, together with all other previous or anticipated recoveries, fully compensates the covered person for any damages the covered person may have experienced. This provision is effective regardless of whether an agreement to this effect is actually signed. The Plan's rights of full recovery, either by way of subrogation or right of reimbursement, may be from funds the covered person receives or is entitled to receive from the third party, any liability or other insurance covering the third party, the Participant's own uninsured motorist insurance or underinsured motorist insurance, any medical, disability or other benefit payments, no-fault or

school insurance coverage, other amounts which are paid or payable to or on behalf of the Participant or in the sole discretion of the Plan, by offset of future benefits due the Participant under the Plan until the Participant's obligations hereunder are satisfied in full. The Plan may enforce its reimbursement or subrogation rights by requiring the Participant to assert a claim to any of the foregoing coverage to which he or she may be entitled. The Plan will not pay attorney fees or costs associated with the Participant's claim without prior express written authorization by the Plan. The Plan will not be subject to the "make whole" doctrine, the "common-fund" doctrine or other similar common-law subrogation rules or legal theories.

Also, each Participant, as a condition for and consequence of receiving medical, disability or any other benefits under the Plan with respect to any amount that is subject to this subrogation provision, agrees as follows:

(a). The Participant (or her attorneys or other Authorized Representatives) will promptly inform the Plan of any settlement agreement and to provide reasonable advance notice of any plans for the disbursement of any settlement funds to the Participant (or to any other person on behalf of the Participant);

(b). The Participant (or her attorneys or other Authorized Representatives) will hold any settlement funds received with respect to a claim that is subject to the Plan's subrogation rights in trust for the benefit of the Plan until all obligations to the Plan under this subrogation provision are satisfied (or to disburse such funds to the Plan to satisfy any obligations to the Plan under this subrogation provision);

(c). The Participant (or her attorneys or other Authorized Representatives) will maintain and treat any settlement funds received by or on their behalf, as Plan assets, to the full extent of any benefits paid by the Plan with the Participant being a trustee of Plan assets with respect to such amounts until Participant's obligations under this subrogation provision are satisfied; and

(d). The Participant (or her attorneys or other Authorized Representatives) agree that the Plan has an equitable lien on any settlement funds payable to or on behalf of the Participant to the full extent of any benefits paid by the Plan amounts until the covered person's obligations under this subrogation provision are satisfied in full.

8.8 HIPAA RULES. Notwithstanding any provision of the Plan to the contrary, to the extent applicable, the Plan shall be administered at all times in accordance with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

8.9 STATUTE OF LIMITATIONS. Notwithstanding any otherwise applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under this Plan more than 6 months after the final review decision by the Administrator has been rendered (or deemed rendered).

8.10 HEALTHCARE INTEGRITY AND PROTECTION DATA BANK. To the extent required by §221(a) of the HIPAA and applicable regulations, the Plan will report any "final adverse action" (as described under those regulations) taken on behalf of the Plan to the Healthcare Integrity and Protection Data Bank.

SIGNATURES ON FOLLOWING PAGE

IN WITNESS WHEREOF, the JOHNS HOPKINS UNIVERSITY has caused this document to be executed effective as specified herein.

THE JOHNS HOPKINS UNIVERSITY

By:_____

Heidi Conway, Vice President for Human Resources

Print Name: _____

Date: _____

Schedule A Schedule of Benefits and Exclusions

Johns Hopkins University 2019-2020 Schedule of Medical Benefits

Group Number ST0858SH

BENEFITS	In-Network	Out-of-Network
Plan Year Maximum Benefit (Including Medical Evacuation & Repatriation	Unlimited	
Plan Year Deductible, Per Covered Person **The Plan will waive the Annual Deductible for Second Surgical Opinions, Immunizations, Preventive Care, Routine Gynecological Care, Urgent Care Expenses, Prosthesis required as a result of Mastectomy and Pap Smears** (Waived for all in-and out of network preventive care)	$150 per plan year (Students' deductible reduced to $75 with a referral* from the Student Health & Wellness Center, Counseling Center or the Georgetown University Student Health Center)	
Plan Year Deductible, Per Family (Waived for all in-network preventative care)	$450 per plan year	

*. A Covered Student should first seek treatment at the Student Health & Wellness Center, Counseling Center, Georgetown University Student Health Center, or the University of Bologna Counseling Center (UNIBO) to obtain a referral to an outside provider. The Deductible will be reduced if treatment is initiated at these facilities. The Covered Student must be seen by a provider onsite and will not be issued a referral over the phone. Any treatment initiated while away from campus will be subject to the $150 annual Deductible. Full-Time Arts and Science, Engineering, Peabody and Carey Business School students have access to the Johns Hopkins Student Assistance Program. Should the Program refer a student for additional treatment, the annual Deductible will be reduced to $75.

The annual Deductible will be reduced to $75 when a Johns Hopkins University (JHU) student athlete covered under the Student Health Benefit Plan obtains a referral from the JHU Athletic Trainer.

Covered students who are enrolled in Carey Business School, School of Education, AAP (Advanced Academic Programs), EP (Engineering for Professionals) will be subject to the $150 Deductible.

*Dependents are not eligible to use the services of the Student Health & Wellness Center, the Counseling Center ,the Georgetown University Student Health Center or the University of Bologna Counseling Center) process.

*A referral is not required in the following circumstances:

- Treatment is for an Emergency Medical Condition,
- Obstetric and Gynecological Treatment,
- Mammogram
- Pediatric Care,
- Preventive/Routine Services (services considered preventive according to the Affordable Care Act

Out-of-Pocket Maximum	$3,000 per Individual/$9,000 Family	$7,750 per Individual/$15,500 Family

INPATIENT HOSPITALIZATION BENEFITS	In-Network	Out-of-Network
Hospital Room and Board Expense	90% of Preferred Allowance (PA)	64% of Reasonable and Customary Charges (R&C)

Miscellaneous Hospital Expense. Services include anesthesia and operating room; laboratory tests and x-rays; oxygen tent; and drugs; medicines; and dressings.	90% of PA	64% of R&C
In-Hospital Non-Surgical Physician Expenses. Services of a Doctor during hospital confinement. This benefit does not apply when related to surgery.	90% of PA	64% of R&C
Pre-certification simply means calling prior to treatment to obtain approval for a medical procedure or service. Pre-certification may be done by you, your doctor, a hospital administrator, or one of your relatives. All requests for certification must be obtained by contacting Cigna at (800) 633-7867.The following inpatient services require pre-certification: • All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility. • All inpatient maternity care, after the initial 48/96 hours. • All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse. ***If you do not secure pre-certification your Covered Medical Expenses will be subject to a $200 per admission charge.***		
SURGICAL BENEFITS (INPATIENT AND OUTPATIENT)	**In-Network**	**Out-of-Network**
Surgical Expense. Expenses incurred for a surgical services, performed by a Physician.	90% of PA	64% of R&C
Anesthesia Expense. Charges of anesthesia during a surgical procedure.	90% of PA	64% of R&C
Assistant Surgeon Expense. Charges of an assistant surgeon during a surgical procedure.	90% of PA	64% of R&C
Ambulatory Surgical Expense. Charges incurred for outpatient surgery performed in a hospital outpatient surgery department or in an ambulatory surgical center. Must be incurred on the date of surgery or within 48 hours after surgery.	90% of PA	64% of R&C
Pre-Admission Testing Expense. Charges incurred while outpatient before scheduled surgery	90% of PA	64% of R&C
Surgical Second Opinion Expense	100% of PA	100% of R&C
Acupuncture in Lieu of Anesthesia Expense	90% of PA	64% of R&C
OUTPATIENT BENEFITS	**In-Network**	**Out-of-Network**
Covered Medical Expenses. Include but are not limited to, Physician's office visits, Hospital or Outpatient Department or Emergency Room visits, durable medical equipment, Clinical lab or Radiological facility.		
Hospital Outpatient Department	90% of PA	64% of R&C
Walk-In Clinic Visit Expense	90% of PA	64% of R&C
Emergency Room Expense. Charges for treatment of an Emergency Medical Condition. *No referral required. When a student presents to the Emergency Room the Deductible is automatically reduced to $75 for the ER charges only (facility, doctor and ancillary charges). However, follow-up care should be coordinated through the Health Services. If a referral is not received for the follow-up care, then the student will have to meet the balance of the $150 Deductible.*	100% of PA Subject to Deductible After $50 copay	100% of R&C Subject to Deductible After $50 copay

Urgent Care Expense. Charges for an urgent care provider to evaluate and treat an urgent condition. (Deductible Waived)	100% of PA after $50 copay	100% of PA after a $50 copay
Ambulance Expense. Charges for a commercial or municipal ambulance for transportation to a Hospital or between Hospitals or other medical facilities in a Medical Emergency due to covered accident or sickness. (Deductible Waived)	100% of Actual Charge	
Primary Care Physician Visit. Includes services rendered by physician for initial treatment/diagnosis	90% of PA after $20 copay	64% of R&C
Physician Office Visits Expense. Includes services rendered by a specialist and telemedicine services and services by a Consultant (services must be requested by the attending physician for the purpose of confirming or determining a diagnosis).	90% of PA	64% of R&C
Acupuncture Services	90% of PA	64% of R&C
Laboratory and X-ray Expense. Includes diagnostic services, laboratory and x-ray examinations.	90% of PA	64% of R&C
High-Cost Procedures Expense. Services include, but are not limited to C.A.T. Scans, MRI and Laser Treatments as a result of injury or sickness.	90% of PA	64% of R&C
Therapy Expense. Includes Physical Therapy. Chiropractic Care, Speech Therapy, Cardiac Rehabilitation, Inhalation Therapy, Occupational Therapy, Radiation Therapy, Chemotherapy, Dialysis and Respiratory Therapy.	90% of PA	64% of R&C
Durable Medical Equipment Expense	90% of PA	90% of R&C
Prosthetic Devices Expense. Includes charges for: artificial limbs, or eyes, and other non-dental prosthetic devices, as a result of accident or sickness and wigs required as a result of chemo or radiation therapy.	90% of PA	90% of R&C
Dental Injury Expense. For injury to sound natural teeth.	90% of Actual Charge	
Impacted Wisdom Teeth Expense. For removal of one or more impacted wisdom teeth.	90% of Actual Charge	
General Anesthesia for Dental Care Expense	90% of PA	64% of R&C
Allergy Testing and Treatment Expense. Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	90% of PA	64% of R&C
MENTAL HEALTH BENEFITS	**In-Network**	**Out-of-Network**
Mental Health /Outpatient Expense	90% of PA	64% of R&C
Mental Health Inpatient Expense	100% of PA for first 30 visits then 80% of PA	64% of R&C
Substance Abuse Outpatient Expense. Includes inpatient and intermediate treatment services for substance abuse.	90% of PA	64% of R&C
Substance Abuse Inpatient Expense	100% of PA for first 30 visits then 80% of PA	64% of R&C
Diagnostic Testing for Attention Disorders and Learning Disabilities Expense. Includes Diagnostic testing for attention deficit disorder or attention deficit hyperactivity disorder.	80% of PA	64% of R&C

MATERNITY BENEFITS	In-Network	Out-of-Network
Maternity Expense / Newborn Nursery Care. Includes pregnancy, complications of pregnancy, childbirth, other pregnancy-related expenses and inpatient care of the covered person and any newborn child for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery.	90% of PA	64% of R&C
Prenatal Care and Comprehensive Lactation Support. Includes services received by a pregnant female in a physician's, obstetrician's or gynecologist's office and lactation support and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider.	100% of PA	84% of R&C
Breast Feeding Durable Medical Equipment Expense. Includes the rental or purchase of breast feeding durable medical equipment for the purpose of lactation support (pumping and storage of breast milk).	100% of PA	84% of R&C
ADDITIONAL BENEFITS	**In-Network**	**Out-of-Network**
Wellness/Preventive and Immunizations Expenses. Includes but is not limited to; Routine Physicals, Preventive Care Visits, Laboratory Services, Immunizations (including titers) & Vaccines, GYN exams, Prostate exam and Routine Prostate Cancer Screening. **(For more information, please visit: www.healthcare.gov/prevention)**	100% of PA	84% of R&C
Pap Smear Screening Expense	100% of PA	100% of R&C
Mammogram Expense Testing Expense	100% of PA	100% of R&C
Diabetic Supplies & Outpatient Diabetic Self-Management Education Program	90% of PA	64% of R&C
Non-Prescription Special Medical Formulas Expense	90% of PA	64% of R&C
ADDITIONAL BENEFITS (continued)	**In-Network**	**Out-of-Network**
Non-Prescription Enteral Formula Expense. Includes treatment of malabsorption caused by the following: • Crohn's Disease, • Ulcerative Colitis, • Gastroesophageal Reflux, Gastrointestinal Motility, • Chronic Intestinal Pseudoobstruction • Inherited diseases of amino acids and organic acids.	90% of PA	64% of R&C
Medical Foods and Modified Food Products Expense. Includes medical foods and low protein modified food products for the treatment of inherited metabolic disease when authorized by, and administered under the direction of, a Physician.	90% of PA	64% of R&C
Home Health Care Expense	90% of PA	90% of R&C
Hospice Care Expense	90% of PA	64% of R&C
Hormonal testing	90% of PA	64% of R&C
Transfusion or Dialysis of Blood Expense. Includes the cost of whole blood, blood components and the administration thereof.	90% of PA	64% of R&C
Licensed Nurse and Consulting Expense	90% of PA	64% of R&C

Skilled Nursing Facility Expense	90% of PA	64% of R&C
Rehabilitation Facility Expense	90% of PA	64% of R&C
Cleft Lip/Cleft Palate Treatment Expense	90% of PA	64% of R&C
Clinical Trial Costs Expense	90% of PA	64% of R&C
Speech, Hearing and Language Disorders Expense	90% of PA	64% of R&C
Habilitative Services Expense	90% of PA	64% of R&C
Early Intervention Services Expense	100% of PA	100% of R&C
Outpatient In Vitro Fertilization/ Infertility Expense	90% of PA	64% of R&C
Outpatient Contraceptive Drugs, Devices and Family Planning Services Expense	100% of PA	84% of R&C
Alzheimer's Disease Expense	90% of PA	64% of R&C
Hearing Aid Expense. This benefit is limited to one hearing aid for each impaired ear, every 36 months	90% of PA	64% of R&C
Routine Vison Care for Children under age 19 One exam/fitting per plan year, including prescription eyeglasses (lenses and frames, limited to one per plan year) or contact lenses (in lieu of eyeglasses). Includes coverage of contact lenses when medically necessary for treatment of Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders and Irregular Astigmatism. Eyeglass lenses include glass or plastic lenses, all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Includes coverage of the following benefits for low vision: one comprehensive low vision evaluation every five years, one medically necessary low vision aid every five years, such as high-power spectacles, magnifiers or telescopes; and follow-up care – four visits in any five year period. Precertification is required for all low vision services.	100% of PA	84% of R&C

Dental Care for Children under age 19		
Preventive	100% of R&C	
Basic Dental Care	70% of R&C	
Major Dental		
(Endodontics, Periodontics and Prosthedontics	50% of R&C	
Orthodontics	50% of R&C	
(Only provided for a patient with a severe, Dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the Handicapping Labio-Lingual Deviations form, excluding points for esthetics. Routine orthodontia is not covered.		
Scalp Hair Prostheses	90% of PA	64% of R&C
Coverage for Bones of Face, Neck and Head Expense	90% of PA	64% of R&C
Reconstructive Breast Surgery, Post Hospitalization and Mastectomy Prosthetic Devices Expense	90% of PA	64% of R&C
Treatment of Morbid Obesity Expense	90% of PA	64% of R&C
Assessment of Metabolic Risk (in a patient whose Body Mass Index (BMI) is 25 kg/m^2 or greater to include: (1) fasting lipid profile, (2) TSH, (3) liver enzymes, and (4) a fasting glucose or hemoglobin A1C level	90% of PA	64% of R&C
Prosthetic and Orthopedic Devices Expense	90% of PA	90% of R&C
Transgender Surgery Expenses	90% of PA	64% of R&C

PRESCRIPTION DRUG BENEFIT	At SH&WC	In-Network	Out-of-Network
Prescription Drug Benefit. *(Note: Prescription* Drugs *considered to be wellness/preventive under the Affordable Care Act (ACA), including prescription contraceptives, are payable with no cost sharing. Co-payment will apply for a Brand drug when there is a Generic equivalent available.)* Co-pays per 30-day supply Three (3) month supply at retail pharmacy available for two (2) copays.	$8 SH&WC co-pay per prescription	Plan pays 100% of the Negotiated Rate after $15 co-pay for a generic drug, $0 co-pay for generic contraceptives, or $25 co-pay for a brand name drug	100% of R&C after $15 Deductible for each Generic Prescription Drug; $ 25 Deductible for each Brand Name Prescription You must pay out-of-pocket for prescriptions at a Non-Preferred pharmacy and then submit the receipt for reimbursement

Travel Vaccines: Travel vaccine coverage includes all routine vaccines recommended for adults (including any needed booster doses) plus any vaccines specifically recommended due to travel to designated countries (e.g., yellow fever, Japanese encephalitis, polio, typhoid [both oral and injectable], influenza, meningococcal, hepatitis B). Medications prescribed for Malaria prophylaxis (including doxycycline and atovaquone/progunail) are also covered and do not require prior authorization).	100%	90% of PA	64% of R&C

COVERED MEDICAL SERVICES

COVERED MEDICAL SERVICES

Benefits subject to applicable Deductible, Coinsurance, and copayments as outlined in the Schedule of Benefits, and subject to all other provisions, limitations and exclusions within the Plan.

A. Inpatient Hospitalization Benefits

a. Hospital Room and Board

Charges made by a Hospital for room and board in a semiprivate room, Intensive Care Unit, cardiac care unit, or burn care unit, but excluding charges for a private room (unless Medically Necessary) which are in excess of the Hospital's semiprivate room rate.

b. In-Hospital Physician Expenses.

Charges for the non-surgical services of the attending Physician, or a consulting Physician.

c. Miscellaneous Hospital Expense.

- Charges made by a Hospital for necessary medical supplies and services, including X-rays, laboratory, and anesthetics and the administration thereof; and
- Charges made by a Hospital for drugs and medicines obtained through written prescription by a Physician.

NOTE: All inpatient hospital admissions, convalescent facility, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment and all inpatient maternity care after the initial 48/96 hours require pre-certification. If you do not secure pre-certification for non-emergency inpatient admissions, or provide notification for emergency admissions, your Covered Medical Expenses will be subject to a $200 per admission charge.

B. Surgical Benefits (Inpatient and Outpatient)

a. Acupuncture in Lieu of Anesthesia

Covered Charges as described in the schedule of benefits will include services administered by a legally qualified Physician, Nurse Practitioner or Physician Assistant participating within the scope of their license for:

- Adult postoperative and chemotherapy nausea and vomiting;
- Nausea due to Pregnancy;
- Postoperative dental pain;
- Chronic low back pain secondary to osteoarthritis; and
- Fibromyalgia/myofacial pain.

a. Ambulatory Surgical

- Charges incurred for outpatient surgery performed at a Physician's office, Ambulatory Surgical Center, the outpatient department of a Hospital, Birthing Center or Freestanding Health Clinic;
- Charges must be incurred on the date of surgery or within 48 hours after surgery.

b. Anesthesia

Charges for anesthesia during a surgical procedure.

Charges for anesthesia and associated Hospital or Ambulatory Surgical Center in conjunction with dental care provided to a Covered Person who:

- is seven (7) years of age or younger or is developmentally disabled;
- is an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or Insured; and
- is an individual for whom a superior result can be expected from dental care provided under general anesthesia.

Such charges will also be covered when provided in conjunction with dental care provided to a Covered Person who:

- is an extremely uncooperative, fearful, or uncommunicative person with dental needs of such magnitude that treatment should not be delayed or deferred; and
- is an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

c. Assistant Surgeon

The SHBP will pay for a surgical assistant when the nature of the procedure is such that the services of an assistant, who is a Physician, are Medically Necessary.

d. Mastectomy

When services relating to a mastectomy are Medically Necessary, coverage will include:

- Treatment of the physical complication of the mastectomy, including lymphedema;
- All stages of reconstruction of the breast on which the mastectomy was or is to be performed;
- Prosthesis; and
- Surgery and reconstruction of the other breasts to produce a symmetrical appearance.
-

e. Transgender Reassignment Surgery

The Plan allows coverage for gender reassignment surgery when all of the following criteria are met:

1. Requirements for mastectomy for female-to-male patients:
    1. Single letter of referral from a qualified mental health professional; *and*
    2. Persistent, well-documented gender identity disorder ; *and*
    3. Capacity to make a fully informed decision and to consent for treatment; *and*
    4. Age of majority (18 years of age or older); *and*
    5. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Note that a trial of hormone therapy is not a pre-requisite to qualifying for a mastectomy.

2. Requirements for gonadectomy (hysterectomy and oophorectomy in female-to-male and orchiectomy in male-to-female):
    1. Two referral letters from qualified mental health professionals, one in a purely evaluative role; *and*
    2. Persistent, well-documented gender identity disorder; *and*
    3. Capacity to make a fully informed decision and to consent for treatment; *and*

4. Age of majority (18 years or older); *and*
5. If significant medical or mental health concerns are present, they must be reasonably well controlled; *and*
6. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones)

3. Requirements for genital reconstructive surgery (i.e., vaginectomy, urethroplasty, metoidioplasty, phalloplasty, scrotoplasty, and placement of a testicular prosthesis and erectile prosthesis in female to male; penectomy, vaginoplasty, labiaplasty, and clitoroplasty in male to female)
    1. Two referral letters from qualified mental health professionals, one in a purely evaluative role; and
    2. Persistent, well-documented gender identity disorder; and
    3. Capacity to make a fully informed decision and to consent for treatment; and
    4. Age of majority (age 18 years and older); and
    5. If significant medical or mental health concerns are present, they must be reasonably well controlled; and
    6. Twelve months of continuous hormone therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); and
    7. Twelve months of living in a gender role that is congruent with their gender identity (real life experience).

Note: Rhinoplasty, face-lifting, lip enhancement, facial bone reduction, blepharoplasty, breast augmentation, liposuction of the waist (body contouring), reduction thyroid chondroplasty, hair removal, voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which have been used in feminization, are considered cosmetic. Similarly, chin implants, nose implants, and lip reduction, which have been used to assist masculinization, are considered cosmetic.

Note on gender specific services for transgender persons:

Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. Examples include:

1. Breast cancer screening may be medically necessary for female to male transgender persons who have not undergone a mastectomy;
2. Prostate cancer screening may be medically necessary for male to female transgender individuals who have retained their prostate.

f. Pre-Admission Testing

Charges made for preadmission tests on an outpatient basis for a scheduled Hospital admission or surgery.

g. Surgical

If two (2) or more surgical procedures are performed at one (1) time through the same incision in the same operative field, the maximum allowable amount for the surgery will be either the amount for the primary procedure and 50% of the amount for the secondary or lesser procedure(s), or if not in the network, the Reasonable and Customary Charge for the major procedure and 50% of the Reasonable and Customary Charge for the secondary or lesser procedure(s). No additional benefit will be paid under the SHBP for incidental surgery done at the same time and under the same anesthetic as another surgery.

NOTE: Necessary surgical procedures incidental to providing a wellness benefit required by the SHBP's voluntarily compliance with HHS guidelines will be covered at the same rate as any other Wellness expense. Surgical procedures not required under HHS regulations, such as vasectomies, will be paid as any other Covered Medical Expense.

Coverage is provided for a Covered Person who receives less than forty-eight (48) hours of inpatient hospitalization following the surgical removal of a testicle, or who undergoes the surgical removal of a testicle on an outpatient basis, as follows:

C. Outpatient Benefits

Covered Medical Expenses include but are not limited to, Physician's Office Visits, Hospital or Outpatient Department or Emergency Room Visits, Durable Medical Equipment, Clinical Lab or Radiological Facility.

a. Allergy Testing and Treatment

Covered charges include charges incurred for diagnostic testing of allergies and immunology services including but not limited to:

- Laboratory tests,
- Physician office visits (including visits to administer injections),
- Prescribed medication for testing,
- Other Medically Necessary supplies and services.

b. Ambulance Services

Charges incurred for a professional ambulance for transportation to a hospital, or between hospitals or other medical facilities when required due to the emergency nature of a covered Accident or Sickness.

c. Dental Injury

Coverage includes dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, and/or reposition sound natural teeth that are damaged, lost, or removed and other body tissues of the mouth fractured or cut due to a covered injury, provided:

- The tooth is be free from decay, in good repair, and firmly attached to the jawbone at the time of the injury.
- The injury is from damage other than eating or chewing.

Covered benefits include:

- The first denture or fixed bridgework to replace lost teeth,
- The first crown needed to repair each damaged tooth,
- An in-mouth appliance used in the first course of orthodontic treatment after the injury,
- Surgery needed to: treat a fracture, dislocation or wound; alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

d. Durable Medical Equipment

Coverage will be provided for no more than one (1) item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- Made to withstand prolonged use,
- Made for and mainly used in the treatment of a disease or injury,
- Suited for use in the home,
- Not normally of use to person's who do not have a disease or injury,
- Not for use in altering air quality or temperature,
- Not merely for convenience or independence such as phone alerting systems, massage devices, over bed tables, communication aids, or other such item,
- Not for exercise or training.

e. Emergency Room

Charges incurred for Medically Necessary care at an emergency treatment center, walk in medical clinic or ambulatory clinic (including clinics located at a Hospital).

f. High-Cost Procedures Expense

Charges for High Cost Procedures include charges for the following procedures and services:

- C.A.T. Scan;
- Magnetic Resonance Imaging; and
- Contrast Materials for these tests.

g. Hospital Outpatient Department or Walk-in Clinic

- Outpatient department charges;
- Benefits do not include expenses incurred for the use of an outpatient surgical facility.

h. Laboratory and X-ray

Charges incurred for X-rays, microscopic tests, laboratory tests, electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved and performed by Physicians throughout the United States.

i. Physician Office Visits

Charges made by legally-licensed Physician, Nurse Practitioner or Physician Assistant for medical care and/or treatment including office visits, hospital outpatient visits/exams, telemedicine services, and clinic care.

Coverage is also provide on a nondiscriminatory basis for covered services when delivered or arranged by a participating nurse practitioner with no annual service limitation that is less than other preferred care providers. If the services are in connection with surgery and the physician is the surgeon who performed the surgery, no benefits will be payable under this provision.

j. Therapy

Charges for the following types of outpatient therapies:

- Physical Therapy
- Chiropractic Care
- Speech Therapy
- Inhalation Therapy
- Cardiac Rehabilitation
- Occupational Therapy
- Radiation Therapy
- Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy
- Dialysis
- Respiratory Therapy

k. Urgent Care

Covered charges include treatment by an urgent care provider to evaluate and treat a non-emergency condition.

A covered person should not seek medical care or treatment form an urgent care provider if their illness, injury, or condition is an emergency condition. The Covered Person should call 911 or go directly to the emergency room of a hospital for medical assistance.

A Covered Person should not be discouraged from exercising the option of calling the local

pre-hospital emergency medical service system by dialing 911 (or its local equivalent) when he or she is confronted with an emergency medical condition.

D. Maternity Benefit:

a. Maternity

- Prenatal care of the mother and/or fetus is treated as any other Covered Medical Expense.
- Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However the mother's or newborn's attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In such cases, covered services may include, Home Visits, Parent Education, and assistance and training in breast or bottle-feeding and the performance of any necessary and appropriate clinical tests, provided, however, that the first (1st) home visit be conducted by a Registered Nurse, Physician, or certified nurse midwife, and provided that any subsequent home visits determined to be clinically necessary shall be provided by a licensed health care provider.
- Authorization is not needed for initial inpatient care, however, should care be needed longer than the 48/96 hours described above, written documentation of medical necessity may be required.
- Covered medical expenses include services of a certified nurse midwife, provided that expenses for such services are reimbursed when such services are performed by any other duly licensed practitioner.
- Complications of pregnancy, including abortions, are considered a sickness and are covered under this benefit.
- Charges made by a Birthing Center or Freestanding Health Clinic (Payment will be limited to the amount that would have been paid if that person were in a Hospital.)

b. Newborn Nursery Care

Covered Charges will include benefits for routine care of a covered person's newborn child as follows:

- Hospital charged for routine nursery care during the mother's confinement, but for not more than four (4) days for a normal delivery;
- Physician's charges for circumcision; and
- Physician's charges for visits to the newborn child in the hospital and consultations, but not for more than one (1) visit per day.

E. Additional Benefits:

a. Alzheimer's Disease

Covered Medical Expenses include care for Alzheimer's disease, including nursing home care for intermediate and custodial levels of care.

b. Amino Acid-Based Elemental Formula

Covered Medical Expenses include coverage for amino acid-based elemental formula for the diagnosis and treatment of:

- Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- Severe food protein induced enterocolitis syndrome;
- Eosinophilic disorders, as evidenced by the results of a biopsy; and
- Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

c. Antigen Testing

Coverage will be provided for Human Leukocyte Antigen or Histocompatibility Locus Antigen testing necessary to establish bone marrow transplant donor suitability. Coverage shall include

the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the department of public health.

d. Blood Products

Coverage is provided for blood products, other than whole blood or concentrated red blood cells.

e. Bone Marrow Transplants for Breast Cancer

Covered Charges for expenses incurred by a covered person who has been diagnosed with breast cancer that has progressed to the metastatic disease as follows:

- If recommended by the treating oncologist, referral to and participation in clinical trial on the grounds that the proposed procedure shows promise as a useful treatment for the Covered Person's Cancer and is likely to be at least as effective as conventional treatment;
- A bone marrow transplant, provided the Covered Person meets the criteria established for enrollment in a clinical trial even if not formally enrolled in the clinical trial; and
- Coverage for the bone marrow transplant itself.

The clinical trial will be conducted:

- At a licensed health facility which participates in a National Cancer Institute (NCI) sponsored or approved research in any cancer specialty area, or
- At a licensed health facility which has a formal agreement with an academic medical center to provide bone marrow transplantation as part of an NIC sponsored approved research protocol.

Definitions:

- "Bone Marrow Transplant" means use of high dose chemotherapy and radiation in conjunction with transplant of autologuous bone marrow or peripheral blood stem cells which originate in the bone marrow.
- "Metastatic Disease" means Stage III and Stage IV breast Cancer, as well as stage II breast cancer which has spread to ten (10) or more lymphnodes, as defined by the American College of Surgeons.

f. Cardiac Rehabilitation

Such treatment shall be initiated within 26 weeks after the diagnosis of such disease and be recommended by the attending Provider/Practitioner. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, highly supervised with a tailored exercise program with continuous monitoring during exercise. Phase II consists of outpatient supervised treatment for Covered Persons who have left the Hospital but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the Covered Person's individual needs. Benefits are not payable for Phase III, which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.

g. Cleft Lip and Cleft Palate Treatment Expense

Include inpatient and outpatient charges incurred for a congenital cleft lip or cleft palate or both. Such charges are included to the extent they would have been so included if incurred for treatment of a disease.

Covered treatment means any of the services or supplies listed below given for the management of the birth defect known as cleft lip or cleft palate or both.

- Inpatient and outpatient orthodontics
- Oral surgery. This includes pre-operative and post- operative care performed by a physician.
- Otologic treatment.
- Audiological treatment
- Speech/language treatment

h. Clinical Trial

Covered charges will include expenses for routine patient costs (as defined in 42 USC §300gg-8(a)) for items and services furnished in connection with participation in a clinical trial that meets the following conditions:

- The purpose of the trial is to treat a Covered Person in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition;
- The Covered Person meets the patient selection criteria enunciated in the study protocol for participation in said clinical trial;
- The available clinical or pre-clinical data provides a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial and that benefits will be at least as effective as a non-trial alternative;
- The patient has provided documentation of informed consent for participation in the clinical trial, in a manner that is consistent with current legal and ethical standards;
- The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient;
- The clinical trial is (A) approved or funded by one or more of (i) the National Institutes of Health (NIH), (ii) the Centers for Disease Control and Prevention, (iii) the Agency for Health Care Research and Quality, (iv) the Centers for Medicare and Medicaid Services, (v) a cooperative group or center of the entities described in clauses (i) through (iv), (vi) a qualified non-governmental research entity identified in guidelines issued by the NIH for center support grants, (vii) the Department of Veterans Affairs, the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed or approved through a system of peer review that meets requirements established by the Secretary of Labor; (B) conducted under an investigational new drug application reviewed by the Food and Drug Administration; or (C) a drug trial that is exempt from having an FDA new drug application;
- The clinical trial does not unjustifiably duplicate existing studies; and
- The facility and personnel conducting the clinical trial are capable of doing so by virtue of their

i. experience and training, and treat a sufficient volume of patients to maintain that expertise.

Coverage for Bones of Face, Neck and Head Expense, Temporomandibular Joint Syndrome (TMJ) Treatment

Coverage is provided for diagnostic or surgical procedures involving a bone or joint of the face, neck or head, on the same basis that coverage is provided for a bone or joint of the skeletal structure. If the procedure is Medically Necessary to treat a Condition caused by a congenital Deformity, disease or injury.

j. Dental Expense for Impacted Wisdom Teeth

Covered Medical Expenses for removal of one or more impacted wisdom teeth.

k. Dermatological

Covered Charges include diagnosis and treatment of skin disorders. Any associated laboratory fees would be provided under the Laboratory expense.

l. Diabetic Testing Supplies & Outpatient Diabetic Self-Management Education Program

Charges incurred for diabetic self-management training, education services, supplies and equipment for the treatment of insulin- and non-insulin-dependent diabetes and elevated blood glucose levels during pregnancy.

- Benefits include:
  - expense for blood glucose monitors;
  - blood glucose monitoring strips for home use;
  - voice-synthesizers for blood glucose monitors for use by the legally blind;
  - visual magnifying aids for use by the legally blind;
  - urine glucose strips;
  - ketone strips;
  - lancets;
  - insulin;

- insulin syringes;
- prescribed oral diabetes medications that influence blood sugar levels;
- laboratory tests, including glycosylated hemoglobin, or HbA1C tests;
- urinary/protein/microalbumin and lipid profiles;
- insulin pumps and insulin pump supplies;
- insulin pens;
- so-called, therapeutic/molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating doctor and prescribed by a podiatrist or other qualified doctor and furnished by a podiatrist, orthotist, prosthetist or pedorthist;
- supplies and equipment approved by the FDA for the purposes for which they have been prescribed and diabetes outpatient self-management training and education, including medical nutrition therapy.

Note: A co-payment for a 30-day supply would apply to items payable under the prescription drug benefit.

m. Surgical Second Opinion

Charges incurred for a second surgical opinion, are as follows:

- fees of a specialist Physician for a second surgical consultation when non-Emergency or elective surgery is recommended by the Covered Person's attending Physician (The Specialist Physician rendering the second opinion regarding the Medical Necessity of such surgery must be board certified in the medical field relating to the surgical procedure being proposed; and
- Covered Charges will include expenses for required x-rays and diagnostic tests done in connection with that consultation.

n. Habilitative Services Expense

Habilitative services that are delivered through early intervention or school services are not covered.

For purposes of this benefit "Habilitative services" means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

For purposes of this benefit, "congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. "Congenital or genetic birth defect" includes, but is not limited to:

- Autism or an autism spectrum disorder;
- Cerebral palsy;
- Intellectual disability;
- Down syndrome;
- Spina bifida;
- Hydroencephalocele; and
- Congenital or genetic developmental disabilities.

o. **Hearing Aid Expense**

Covered Medical Expenses include charges for hearing aids when prescribed, fitted and dispensed by a licensed audiologist. Hearing aid means a device is (a) of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by the Covered Person and (b) non-disposable. This benefit is limited to one hearing aid for each impaired ear every 36 months.

p. Hearing Screening for Newborns

Covered charges for hearing screening service rendered to a dependent child performed before the newborn infant is discharged from the Hospital or birthing center.

q. Home Health Care

Covered Charges include Medically Necessary expenses incurred by a Covered Person for Home Health Services in accordance with a Home Health Care Plan (HHCP) written by the treating Physician.

- Such expenses will only be covered if:
  - Services are furnished by, arranged by, or under the direction of a licensed Home Health Agency.
  - Services are rendered under a HHCP. The plan must be established by the written order of the attending Physician. Such plan must be reviewed by the attending Physician every sixty (60) days. Such Physician must certify that the proper treatment of the condition would require inpatient confinement in a Hospital or Skilled Nursing Facility if the services and supplies were not provided under the Home Health Care Plan. The attending Physician must examine the Covered Person at least once a month.
  - Unless specifically provided in the plan, services are to be delivered in the Covered Person's place of residence on a part-time, intermittent visiting basis.
  - Services must be provided by a certified professional operating within the scope of their license.
  - Each visit that last for a period of four (4) hours or less is treated as one (1) visit.

- No benefits will be provided for services and supplies:
  - Not included in the Home Health Plan;
  - Services of any social worker, transportation services, Custodial Care and housekeeping;
  - Dialysis treatment, purchase or rental of dialysis equipment, food or home delivered services; or
  - For services of a person who ordinarily resides in the home of the Covered Person, or is a close relative of the Covered Person.

r. Hospice Care

Hospice care benefits are provided to a terminally-ill Covered Person with a life expectancy of less than six (6) months; Benefits are limited to:

- Inpatient Care in a Hospital or Hospice facility;
- Ancillary charges furnished by the facility while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an Injury or Illness;
- Medical supplies, drugs, and medicines prescribed by the attending Physician, but only to the extent that such items are necessary for pain control and management of the terminal condition;
- Services and/or nursing care by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or a Licensed Vocational Nurse (L.V.N.), on a part time basis (up to 8 hours in one (1) day);
- Home Health aide services;
- Medical social services by licensed or trained social workers, psychologists, or counselors under the direction of a physician, including the assessment of the person's social, emotional, medical and dietary needs and assessment of the home and family situation;
- Identification of available community resources and assistance in obtaining those resources as noted in the covered person's assessed needs;
- Nutrition services provided by a licensed dietitian;
- Respite care for up to 5 days in any 30 day period; and
- Bereavement counseling.

Bereavement counseling is a support service provided to Covered Person's immediate family both prior to and after the death of the Covered Person. Such visits are to assist in adjusting to the death. Benefits will be payable provided:

- On the date immediately before his or her death, the terminally-ill person was in a Hospice Plan of Care program and was a Covered Person under the SHBP; and

- Charges for such services are incurred by the Covered Person(s) within three (3) months of the terminally-ill person's death.

The term immediate family means: parents, spouse (or domestic partner) and children of the terminally-ill Covered Person.

Bereavement Counseling does not include: funeral arrangements; financial or legal counseling; or homemaker or caretaker services (not otherwise provided in the Home Health Care Plan).

s. Hypodermic Needles

Covered charges include coverage for medically necessary Hypodermic needles and syringes.

t. Infertility

Benefits will be payable for infertility procedures. Infertility is a condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one (1) year. Benefit includes expense incurred for the following non-experimental infertility procedures: artificial insemination (AI), in vitro fertilization and embryo placement (IVF) and male infertility treatments.

Outpatient In Vitro Fertilization Expense

Includes expenses incurred by a female Student Participant or a Student Participant's Spouse or Domestic Partner, who at the time the expenses were incurred, was at least 18 years old, for outpatient in vitro fertilization procedures. These expenses will be covered as any other Covered Medical Expense, provided that the following conditions are met:

- The procedure(s) is/are performed while the patient is not confined in a Hospital or any other facility as an inpatient.
- The patient's oocytes are fertilized with her Spouse's or donated sperm.
- The patient or the patient and her Spouse/Domestic Partner have a history of infertility or the infertility is associated with one or more of the following conditions:
    - Endometriosis
    - Exposure in utero to diethylstilbestrol, known as DES.
    - Blockage of one or both fallopian tubes
    - Surgical removal of one or both fallopian tubes, known as unilateral or bilateral salpingectomy
    - Abnormal male factors, including oligospermia, contributing to infertility
- The patient has been unable to attain a successful pregnancy through any less costly treatments for which coverage is available under the Plan.
- The in vitro fertilization procedures are performed at a facility that:
    - Meets the guidelines for in vitro clinics set by the American College of Obstetricians and Gynecologists, or
    - Meets the American Society for Reproductive Medicine's minimal standards for programs of in vitro fertilization.

Not more than three (3) in vitro fertilization attempts per live birth are covered. Lifetime maximum benefit of $100,000.

u. Licensed Nurse

Covered Charges include charges incurred by a covered person who is confined in an Inpatient basis and requires the medically necessary services of a registered nurse or licensed practical nurse, provided that the nurse is not an immediate family member or resides in the Covered Person's home.

v. Mammography In addition to the Wellness/Preventive and Immunization benefits, coverage is provided in accordance with the latest cancer screening guidelines issued by the American Cancer Society.

w. Medical Evacuation and Repatriation

MEDICAL EVACUATION & REPATRIATION OF REMAINS

Travel Guard services is a comprehensive program providing You with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside Your home country or 100 or more miles away from your permanent residence Travel Guard is your key to travel security.

Medical Evacuation

If the Covered Student cannot continue his/her academic program because he/she sustains an Injury or becomes ill while Covered under the Plan we will pay for the Reasonable and Customary Charges incurred for a medical evacuation of the Covered Person to or back to the Covered Person's home country or country of regular domicile, subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits and subject to the Exclusions and Limitations provisions. No payment will be made under this provision unless the evacuation follows a Hospital Confinement of at least five (5) days. Before we make any payment, we require written certification by the Doctor that the evacuation is Medically Necessary. Any expense for medical evacuation requires Our prior approval and coordination. For International Students once evacuation is made outside the country, Coverage terminates.

Medical Repatriation

If the Covered Person dies while Covered under the Plan, We will pay for the Reasonable and Customary Charge incurred for embalming, and/or cremation and returning the body to his place of residence in his/her home country or country of regular domicile, subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits and subject to the Exclusions and Limitations provision. Expenses for repatriation of remains require the Policyholder's and Our prior approval. If you are a United States citizen, your home country is the United States.

For general inquiries regarding the travel access assistance services coverage, please call Wellfleet at 877-657-5044.

If you have a medical, security, or travel problem, simply call Travel Guard for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-877-305-1966 or if you are in a foreign country, call collect at: 1-715-295-9311.

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. Travel Guard will then take the appropriate action to assist You and monitor Your care until the situation is resolved.

x. Medical Foods and Modified Food Products

y. Non-Prescription Enteral Formula

Covered Charges include Non-Prescription Enteral formulas for which a Physician has issued a written order. Such formulas must be medically necessary for the treatment of malabsorption caused by:

- Ulcerative Colitis,
- Chronic intestinal pseudo-obstruction,
- Crohn's disease,
- Gastroesophageal motility problems,
- Gastroesophageal reflux, and

- Inherited diseases of amino acids and organic acids (including food products modified to be low protein).

z. Outpatient Contraceptive Drugs, Devices and Services

Covered Charges include:

- Charges incurred for Contraceptive drugs and devices that have been approved by the FDA and legally require a Physician's prescription.
- Related Outpatient services such as: consultations, exams, procedures, and other contraceptive related services and supplies.
- Additional contraceptive packs are covered when medically necessary.

Covered Charges do not include:

- Charges incurred while confined on an Inpatient basis; and
- Charges incurred for duplicate, lost, stolen, or damaged contraceptive devices.

NOTE: Necessary surgical procedures incidental to providing a wellness benefit required by the SHBP's voluntarily compliance with HHS guidelines will be covered at the same rate as any other Wellness expense. Surgical procedures not required under HHS regulations, such as vasectomies, will be paid as any other Covered Medical Expense.

aa. Pediatric Preventive Care

Includes covered charges for physical examination history measurements sensory screening neuropsychiatric evaluation and developmental screening, and assessment of dependent children of the covered person from birth through age six (6). Services shall include hereditary and metabolic disease(s) screening at birth, appropriate immunizations and tests recommended by the physician.

bb. Podiatric

Covered Charges include medically necessary Outpatient Podiatric services.

cc. Prescription Drug Benefit

This Pharmacy benefit is provided to cover Medically Necessary Prescriptions associated with a covered condition. Prescription drugs include:

- "Off-label" drugs for the treatment of HIV/AIDS or cancer, will not be excluded on the grounds that the drug has not be approved by the U.S. FDA for that indication, if such drug is recognized for the treatment of such indication in one (1) of the standard reference compendia, in medical literature.
- Services associated with the administration of a Prescription drug are covered as any other medically necessary service when recommended by the treating Physician as part of the Prescription.
- This benefit includes: blood glucose monitoring strips, urine glucose strips, keotone strips, lancets, insulin syringes, insulin pumps and insulin pump supplies, insulin pens, insulin and oral medications. A co-payment will be required for a thirty (30) day supply.

Not all medications are covered. For more information on covered medications contact Cigna.

dd. Prosthetic Device

Covered Charges include artificial limbs, or eyes, and other non-dental prosthetic devices that are medically necessary as the result of an injury or illness.

Covered Charges do not include: Eye exams, eyeglasses, vision aids, hearing aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet (except as required to prevent complications from diabetes).

This exclusion from Covered Charges in the preceding sentence does not apply to Routine Vision Care for Children under age 19 described in the Schedule of Benefits.

ee. **Rehabilitation Facility**

Covered Charges for expenses incurred by a covered person for confinement as a full time Inpatient in a Rehabilitation Facility. Confinement must follow within 24 hours of and be for the

same or related cause(s) as, a period of Hospital or Skilled Nursing facility confinement.

ff. Residential Crisis Treatment

Covered Medical Expenses will include expenses incurred by a person for residential crisis services.

"Residential crisis services" means: intensive mental health and support services that are:

- Provided to a child or adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair their ability to function in the community,
- Designed to prevent psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of the inpatient stay,
- Provided out of the individual's residence on a short term basis in a community based residential setting, and
- Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

gg. Scalp Hair Prostheses

Charges for medically necessary wigs and artificial hairpieces, worn for hair loss resulting from any form of cancer or leukemia treatment.

hh. Skilled Nursing Facility

- **Skilled Nursing/Extended Care Facilities:** Inpatient confinement in a Skilled Nursing/extended care facility and/or in a rehabilitation facility/Hospital is provided if:
  - Is in lieu of confinement in a hospital on a full time inpatient basis;
  - Charges are incurred within twenty-four(24) hours following a Hospital confinement for the same or related cause as the confinement;
  - The attending Physician certifies that twenty-four (24) hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the Hospital confinement.

ii. Special Medical Formulas

Covered charges include special medical formulas for newly born infants, adoptive children, and if medically necessary a pregnant women with phenylketonuria. The formulas must be approved by the Commissioner of Health for the medically necessary treatment of an inborn error of metabolism (such as but not limited to Homocystinuria, Methylmalonic acidemia, Maple Syrup Urine Disease, Phenylketonuria, Propionic academia, and Tyrosinemia).

jj. Speech, Hearing and Language Disorders

Covered Charges include medically necessary diagnosis and treatment of speech; hearing; and language disorders if the charges are made for:

- Diagnostic Services rendered to find out if- and to what extent- a covered person's ability to speak or hear is lost or impaired.
- Rehabilitative services rendered that are expected to restore or improve a covered person's ability to speak or hear.

This benefit does not include charges:

- For any ear or hearing exam to diagnose or treat a disease or injury
- For drugs or medications
- For any hearing care service or supply which is a covered expense in whole or in part under any other part of this plan or under any other group plan;
- For any hearing care service or supply which does not meet professionally accepted standards
- For hearing aids, hearing evaluation tests, hearing aid batteries, and the fitting of prescription hearing aids
- For any exam which:
  - Is required by an employer as a condition of employment; or
  - Is required to provide under a labor agreement; or
  - Is required by any law of government;

- For Special Education (including lessons in sign language) to instruct a covered person, whose ability to speak or hear is lost or impaired, to function without that ability;
- For diagnostic or rehabilitative services for treatment of speech, hearing, and language disorders:
  - That any school system, by law, must provide; or
  - As to speech therapy, to the extent such coverage is already provided for under Early Intervention and Home Health Care Services;
  - For any services unless they are provided in accordance with a specific treatment plan, which details the treatment to be rendered and the frequency and duration of the treatment; and
  - Provides for ongoing services, and is renewed only if such treatment is still medically necessary.

kk. Transfusion or Dialysis of Blood

Covered charges for administration of infusions and transfusions (This includes the cost of unreplaced blood and blood plasma or autologuous blood and blood plasma. Expenses for storage of autologuous blood or blood plasma will not be covered.)

ll. Treatment of Morbid Obesity

Coverage is provided for surgical treatment of morbid obesity that is:

- Recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity; and
- Consistent with guidelines approved by the National Institutes of Health.

Surgical treatment of morbid obesity is covered to the same extent as for other Medically Necessary surgical procedures under the Plan.

mm. Wellness/Preventive and Immunizations

As part of the University's voluntary adoption of the U.S Department of Health and Human Services (HHS) benefit requirements for fully insured student health insurance plans, the SHBP will be providing wellness benefits in accordance with government guidelines as listed at www.healthcare.gov/prevention. The following is a sample of the benefits considered preventive under the Affordable Care Act (ACA) as required by HHS Regulations.

"In any event, the following services and supplies are covered without cost sharing:

- Preventive care for adults, children and adolescents, including evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
- Well-child care, including evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
- Well-woman care, including evidence-informed preventive care and screenings for women provided for in comprehensive guidelines supported by the Health Resources and Services Administration;
- Prescription drugs, including prescribed over the counter drugs, that are included in the United States Preventive Services Task Force preventive care recommendations with a rating of A or B:
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention."

nn. Organ Transplants

All Medically Necessary non-experimental/investigational solid organ transplants, and other non-solid organ transplant procedures, are covered the same as any other condition. Covered services include the cost of hotel lodging and air transportation for the recipient Covered Person and a companion (or the recipient Covered Person and two companions, if the Covered Person is under the age of eighteen (18)), to and from the site of the transplant if the transplant is covered.

oo. Pulmonary Rehabilitation

Medically Necessary pulmonary rehabilitation services are covered for Covered Persons who have been diagnosed with significant pulmonary disease or who have undergone certain surgical procedures of the lung, each as determined by the Claims Administrator.

- Coverage is provided to the same extent as for office visits for medical treatment.
- Services must be provided at a place of service approved by the Claims Administrator that is equipped and approved to provide pulmonary rehabilitation services.
- Coverage is not provided for maintenance programs. Maintenance programs consist of activities that preserve the Covered Person's level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur.
- Pulmonary rehabilitation services are limited to one (1) program per lifetime and must be authorized in advance by the Claims Administrator."

F. Pediatric Dental Care:

Preventive Dental Care:

- Cleanings – once every six months.

- Fluoride treatments – topical fluoride varnish up to four times per year. Topical application of fluoride once per six months.

- Sealants – once per lifetime. Teeth 2 - 5, 12 - 15, 18 - 21, 28 - 31 covered only for the occlusal surfaces of posterior permanent teeth without restorations or decay.

- Space maintainers – once every two years.

- Dental examinations – once per six months

- X-Rays:

Bitewing (must be at least age 2)

Full Mouth

Panoramic (must be at least age 6)

Basic Dental Care:

- **Fillings:**

Silver amalgam.

Tooth colored composite.

Generally, once a particular restoration is placed in a tooth, a similar restoration will not be covered for at least 36 months.

Major Dental Care:

- **Crowns/tooth caps:**

Stainless steel crowns – teeth 1-32 once per 60 months per tooth. Teeth A-T once per 36 months per tooth.

Metal (only), metal/porcelain and porcelain crowns – precertification required; once per 60 months per tooth. Pre-operative radiographs of adjacent and opposing teeth required.

- **Root Canals (endodontics):**

Root canals on baby teeth (pulpotomies).

Root canals on permanent teeth – once per lifetime per tooth. Pre-operative and fill radiograph must be maintained in patient record.

Gum (periodontal) therapy – precertification required. Once per 24 months per quadrant.

Dentures:

Partial and complete dentures – precertification and preoperative radiographs required; once per 60 months.

Bridges – not covered.

Oral surgery:

Simple extractions

Surgical extractions
Care of abscesses, including palliative (emergency) treatment of dental pain
Cleft palate treatment – precertification required, must be treatable through orthodontics
Cancer treatment – covered under Surgical Benefits
Treatment of fractures – may require precertification depending on the nature of the fracture
Biopsies – copy of pathology report is required with claim.
Treatment of jaw joint problems (TMJ) – not covered under Dental Benefits.
Emergency room services provided by a dentist – facility and anesthesia charges are covered under Inpatient Hospitalization and Surgical Benefits.
Dental procedures that require emergency care can be reviewed retrospectively to determine coverage under Dental Benefits.

Inpatient Hospital Services:

All dental services that are to be rendered in a hospital setting require precertification. Covered for patients requiring extensive operative procedures and who meet one or more of the following:

- classified by American Society of Anesthesiologists as medically compromised patient whose medical history indicates that the monitoring of vital signs or the availability of resuscitative equipment is necessary
- medical history of uncontrolled bleeding, severe cerebral palsy, or other medical condition that renders in-office treatment not medically appropriate
- documentation of psychosomatic disorders that require special treatment
- cognitively disability where patient's prior history indicates hospitalization is appropriate

Anesthesia:

General anesthesia, nitrous oxide or intravenous conscious sedation – a maximum of 60 minutes of services are allowed. A narrative of medical necessity must be maintained in patient records.
Coverage is provided for extensive or complex oral surgical procedures such as:

- Impacted wisdom teeth
- Surgical root-recovery from maxillary antrum
- Surgical exposure of impacted or unerupted cuspids
- Radical excision of lesions in excess of 1.25 cm

Anesthesia is also covered if medically necessary due to the following medical conditions:

- Medical condition(s) which require monitoring (e.g. cardiac problems, severe hypertension).
- Underlying hazardous medical condition (cerebral palsy, epilepsy, mental retardation, including Down's syndrome) which would render patient noncompliant.
- Documented failed sedation or a condition where severe periapical infection would render local anesthesia ineffective.
- Patients 3 years old and younger with extensive procedures to be accomplished.

Orthodontics:

- Retainers (orthodontic) – precertification required; one set included in comprehensive orthodontia. Replacement allowed once per arch per lifetime within 24 months of date of debanding.
- Braces – precertification required; once per lifetime. Must have a set of fully erupted permanent teeth with at least 1/2 to 3/4 of the clinical crown exposed (unless the tooth is impacted or congenitally missing). Must have a severe, dysfunctional, handicapping malocclusion that meets a minimum score of 15 on the handicapping labio-lingual deviations form (HLD). Since a case must be dysfunctional to be accepted for treatment, patients whose molars and bicuspids are in good occlusion seldom qualify. Crowding alone is usually not dysfunctional in spite of the esthetic considerations. Points are not awarded for esthetics. Specified documentation and treatment plan

must be submitted.

Covered Preventive Services for Adults (a Covered Person age 19 and older)

- Abdominal Aortic Aneurysm one-time screening for men of specified ages who have ever smoked.
- Alcohol misuse screening and counseling.
- Aspirin use for men and women of certain ages.
- Blood pressure screening for all adults.
- Cholesterol screening for adults of certain ages or at higher risk.
- Colorectal cancer screening for adults over age 50.
- Depression screening for adults.
- 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.
- Immunizations and 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
- Prostate exam and routine prostate cancer screening

Covered Preventive Services for Women, including Pregnant Women

- 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 years. See Mammography coverage benefit.
- 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.
- Annual chlamydia infection screening for sexually active women age 25 or younger and 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.
- Annual 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 age 30 or older.
- Osteoporosis screening for women over age 60 depending on risk factors. Further, coverage is provided for bone mass measurement expenses for the prevention, diagnosis and treatment of osteoporosis when provided to a qualified individual.
- Rh Incompatibility screening for all pregnant women and follow-up testing for women at higher risk.
- Tobacco 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 age 65.

Covered Preventive Services for Children (a Covered Person under age 19)

- Alcohol and Drug Use assessments for adolescents.
- Autism screening for children at 18 and 24 months.
- Behavioral assessments for children of all ages (up to age 18).
- Blood Pressure screening for children (up to age 18).
- 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 (up to age 18).
- 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 adolescents at higher risk.
- Immunizations and vaccines for children from birth to age 18 (doses, recommended ages, and recommended populations vary) including:
  - 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.
- 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, and 15 to 17 years).
- Vision screening for all children.

In addition, Coverage will be provided for Annual chlamydia and gonorrhea Screenings for men, which include the mouth, urethra and rectum as indicated.

PREADMISSION/PRECERTIFICATION / CASE MANAGEMENT

Pre-certification simply means contacting the service provider designated by the Plan Administrator, currently, Cigna, prior to treatment to obtain approval for a medical procedure or service. This may be done for you by your doctor, a hospital administrator, or one of your relatives (if they possess a written Protected Health Information (PHI) letter granting access to your health information). All requests for certification must be obtained by contacting Cigna.

If you do not secure pre-certification for a non-emergency inpatient admission or provide notification for an emergency admission within one (1) business day you will be subject to a charge of $200 per admission. This per admission charge cannot be used to satisfy co-payments, deductibles, or out-of-pocket maximums described herein.

Pre-certification is required for the following inpatient or outpatient services or supplies:

- All inpatient admissions to a hospital, convalescent facility, skilled nursing facility, residential treatment facility, and facility established primarily for the treatment of substance abuse. Documentation must include projected length of stay. In the event the number of days of hospitalization exceeds the number of pre-certified days, the additional days will not be an eligible expense under the provisions of this SHBP, unless certified as Medically Necessary care by the Plan Administrator.
- Inpatient maternity care lasting longer than the initial 48 hours for a vaginal delivery or no longer than 96 hours for a cesarean delivery. Documentation must be provided as to expected extension of stay.
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse.

Pre-certification does not guarantee the payment of benefit for your inpatient admission. Each claim is subject to review in accordance with the exclusions and limitations contained in the Plan, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Health Plan.

Pre-certification of Non-Emergency Inpatient Admissions, Partial Hospitalization and Home Health Services must take place at least three (3) business days prior the planned admission or date the services are scheduled to begin.

In the case of an Emergency Admission, the Covered Person, their physician, representative, or care center must contact the Claim Administrator within one (1) business day following the Emergency Admission. If

the Covered Person is confined to the Hospital's observation area for more than 24 hours, it is necessary that the Covered Person contact the Claim Administrator within 48 hours after an admission or on the first business day following admission. If authorization is not obtained, the reduction in benefits described above applies.

Case Management Provision for Alternate Treatment

In cases where a Covered Person's condition is, or is expected to be, of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified agency. This service involves the cost-effective voluntary management of a potentially high-cost claim for a high-risk or long-term medical condition. The intention of the service is to plan necessary, quality care in the most cost-effective manner with the approval of the Covered Person, the family of the Covered Person, and the Primary Care Physician (PCP).

In the event a Covered Person is identified as a candidate for case management a treatment plan is developed and implemented. Such plan is created and approved with input from the Primary Care Physician, the Covered Person, and the Case Management Agency. If either the Primary Care Physician and/or the Covered Person do not wish to follow the developed plan, treatments will continue and benefits will be paid according to the SHBP.

Most of the time, large case management treatment will contain options regularly covered under the SHBP. However, in certain cases, the most medically appropriate and cost effective care may be in a setting or manner not usually covered by the SHBP. In such cases, all Medically Necessary aspects of the approved treatment will be covered under the terms of the SHBP. Such exceptions will be determined on a case by case basis. In no way will an exception be considered as setting a precedent or creating a future liability for any Covered Person. All regular SHBP provisions would still apply.

EXCLUSIONS

No benefits shall be paid under the SHBP for the following expenses:

1. Expenses incurred as a result of dental treatment; except treatment resulting from injury to sound natural teeth; dental abscesses or for extraction of impacted wisdom teeth; except as provided elsewhere in this Plan. This exclusion does not apply to Dental Care for Children under age 19 described in the Schedule of Benefits.
2. Expenses incurred for services normally provided without charge by the Student Health & Wellness Center or the Georgetown University Student Health Center and its health care providers.
3. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aid, or prescriptions or examinations except as required for repair caused by a covered Injury. This exclusion does not apply to a newborn hearing screening test to be performed before the newborn infant is discharged from the Hospital or birthing center to the care of the parent or guardian. This exclusion does not apply to Routine Vision Care for Children under age 19 described in the Schedule of Benefits.
4. Expenses incurred as a result of an Injury due to participation in a riot or attempt to commit a felony. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order. "Riot" means a public and violent disturbance of the peace by three (3) or more persons assembled together.
5. Expenses incurred due to an accident as a consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a commercial airline maintaining regular published schedules on a regularly established rout.
6. Expenses incurred due to an injury or illness as a result of working for wage or profit, or for which benefits are payable under any Worker's Compensation or Occupational Disease Law, Public Assistance Program, or Occupational Benefit Plans.
7. Expenses incurred as the result of an illness contracted or injury sustained while in service of the Uniformed Services of any country. Upon the covered person entering the Uniformed Services of any

country a Covered Person may terminate their participation in this plan and request a pro-rated refund of premium.

8. Expenses incurred in a government hospital unless there is a legal obligation to pay.
9. Expenses incurred for care or services to the extent the charge would have been covered under Medicare Part A or B even though the covered person is eligible, but did not enroll in Part B.
10. Expenses incurred by a Covered Person who is not a citizen of the United States for services performed within the home country of that Covered Person, if the covered person's home country has a socialized medicine program and the covered person is eligible to participate in that program.
11. Expenses incurred for surgery or related services for cosmetic purposes to improve appearance, but this exclusion does not apply to the extent needed to restore bodily function or correct deformity resulting from disease, trauma, congenital, or developmental anomalies.
12. Expenses incurred by a covered person after the date coverage terminates, except as may be specifically provided in the extension of benefits provision.
13. Expenses incurred for services rendered: by a person or individual acting beyond the scope or his or her legal authority; a member of the Covered Person's Immediate Family; or anyone who lived with the Covered Person.
14. Expenses incurred for an injury sustained while a.) participating in any intercollegiate or professional sport, contest or competition; b.) traveling to or from such sport, contest, or competition; c.) while participating in any supervised practice or conditioning program for such sport, contest, or competition; (participation in club or intramural athletic activities is not specifically excluded). Not withstanding the preceding, when combined with the benefits provided by the athletic department, intercollegiate athletes will not incur out of pocket expenses resulting from the practice or play of National Collegiate Athletic Association (NCAA) or National Association of Intercollegiate Athletics (NAIA) sanctioned intercollegiate sports that are substantially different from the benefits provided by this plan. This exclusion also does not apply to the extent that a student has incurred medical expenses that are not covered due to either: (1) the maximum per injury limits of insurance coverage provided by the NCAA or the NAIA; or (2) a specific limitation or exclusion in such NCAA or NAIA coverage, or any other coverage provided by the athletic department for medical expenses incurred in the play or practice of intercollegiate sports, for an expense that is otherwise eligible under this plan.
15. Expenses incurred for procedures that are determined to be experimental or investigational.
16. Custodial Care; Care provided in a: rest home, home for the aged, halfway house, health resort, college infirmary or any similar facility for domiciliary or Custodial Care, or that provides twenty-four (24) hour non-medical residential care or day care (except as provided for Hospice Care).
17. Expenses incurred for the removal of an organ from a Covered Person for the purpose of donating or selling the organ to any person or organization. This limitation does not apply to donation by a Covered Person to a spouse, child, brother, sister or parent.
18. Expense for services or supplies provided for the treatment of obesity and/or weight control, except for morbid obesity unless specifically provided for in this plan.
19. Expenses incurred for gynecomastia (male breasts) except for correction or deformity resulting from mastectomies or lymph node dissections.
20. Expenses incurred for sinus surgery except for medically necessary surgery and purulent sinusitis.
21. Expenses incurred to rent or buy personal hygiene/convenience items (such as air conditioners, humidifiers, hot tubs, whirlpools, general exercise equipment, telephones, TV, radio, extra bed/cot, guest meal, take home items, motorized transportation equipment, escalators or elevators in private homes, swimming pools or related supplies); telephone consolations; standby charges of a physician; charges for missed appointments; photocopies of medical records; completion of forms; or expenses not medically necessary to diagnose or treat an Injury or Illness including but not limited to services related to the activities of daily living.
22. Expenses incurred that were: not recommended by the attending physician; non-medical in nature; not required for the care and treatment of a covered injury or illness; in excess of Reasonable and Customary.

23. Expenses incurred for the treatment of Covered Students who specialize in the mental health care field, who receive treatment as part of their training in that field.
24. Expenses incurred for legend vitamins, food supplements, biological sera, blood plasma, drugs to promote or stimulate hair growth, experimental drugs, drugs dispensed in a rest home or hospital for take home usage, except as specifically provided.
25. Expenses incurred for injury or sickness resulting from declared or undeclared war or any act thereof.
26. Expenses for charges for or related to artificial insemination and elective sterilization or its reversal, unless specifically provided for in this Plan.
27. Expenses for alternative, holistic medicine, and or therapy; including but not limited to yoga, and hypnotherapy.
28. Expenses for massage therapy.
29. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Plan.
30. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.
31. Expenses incurred for which no member of the covered person's immediate family has any legal obligation for payment. However this does not exclude charges made by hospitals and other institutions of the Maryland State or local governments.
32. Expenses incurred for a treatment, service, or supply which is not medically necessary for the diagnosis care or treatment of the sickness or injury involved.
33. Expenses relating to the services of or treatment of surrogates (traditional and gestational).

COORDINATION OF BENEFITS

A. MAXIMUM BENEFITS UNDER ALL PLANS

If any *Covered Person* covered under the SHBP is also covered under one or more Other Plan(s), and the sum of the benefits payable under all the plans exceeds the *Covered Person's* eligible charges during any claim determination period, then the benefits payable under all the plans involved will not exceed the eligible charges for such period as determined under the SHBP. Benefits payable under another plan are included, whether or not a claim has been made. For these purposes,

(1) claim determination period means a *Plan Year*; and
(2) eligible charge means any necessary, *Reasonable and Customary* item of which at least a portion is covered under the SHBP, but does not include charges specifically excluded from benefits under the SHBP that may also be eligible under any Other Plans covering the *Covered Person* for whom the claim is made.

B. OTHER PLANS

Other Plan means the following plans providing benefits or services for medical and dental care or treatment and include:

1) group insurance or any other arrangement for coverage for *Covered Persons* in a group, whether on an insured or uninsured basis;
(2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations (HMOs), *Medicare*, or Medicaid; or
(3) no-fault automobile insurance (for purposes of the SHBP, in states with compulsory no-fault automobile insurance laws, each *Covered Person* will be deemed to have full no-fault coverage to the maximum available in that state. The SHBP will coordinate benefits with no-fault coverage as defined in the state of residence, whether or not the *Covered Person* is in compliance with the law, or whether or not the maximum coverage is carried).

C. DETERMINING ORDER OF PAYMENT

If a *Covered Person* is covered under two or more plans, the order in which benefits will be

determined is as follows.

(1) The plan covering the *Covered Person* as a subscriber pays benefits first. The plan covering the *Covered Person* as an *Eligible Dependent* pays benefits second.

(2) If no plan is determined to have primary benefit payment responsibility under (1) above, then the plan that covered the *Covered Person* for the longest period has the primary responsibility.

(3) A plan that has no Coordination of Benefits provision will be deemed to have primary benefit payment responsibility.

(4) The plan covering the parent of the *Eligible Dependent* child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the calendar year. The plan covering the parent of an *Eligible Dependent* child pays second if the parent's birthday falls later in the calendar year.

(5) In the event that the parents of the *Eligible Dependent* child are divorced or separated, the following order of benefit determination applies:

(a) the plan covering the parent with custody pays benefits first;

(b) if the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second;

(c) if the parent with custody has remarried, then the plan covering the step-parent pays benefits second, and the plan covering the parent without custody pays benefits third; and

(d) if a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the plan covering that parent pays benefits first.

D. FACILITATION OF COORDINATION

For the purpose of Coordination of Benefits, the Claims Administrator:

(1) may release to, or obtain from, any other insurance company or other organization or individual any claim information, and any *Covered Person* claiming benefits under the SHBP must furnish any information that the Plan Administrator may require;

(2) may recover on behalf of the SHBP any benefit overpayment from any other individual, insurance company, or organization; and

(3) has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the SHBP have been made by such organization.

DEFINITIONS

The following are terms used in this Schedule A. To the extent any terms defined below are inconsistent with the same term defined in the Plan document, the term defined below shall control with regard to matters relating to this Schedule A and the term defined in the Plan will control with regard to matters relating to Plan provisions.

Accident: means a sudden specific event that is unforeseen, caused by an external force not due in whole or in part to a sickness or disease of any kind that is the direct cause of a physical injury occurring while the SHBP is in force as to the Covered Person.

Accidental Injury: A specific unforeseen event, which directly, and from no other cause, results in an Injury.

Aggregate Maximum: means the greatest amount of benefit that will be paid under the SHBP for a

Covered Medical Expense incurred by a Covered Person during a Plan Year.

Appeal: means a request that a decision to deny benefits or a claim be reviewed. Such review would include consideration of any relevant information.

Biologically-Based Mental Illness: means a biological disorder of the brain; as defined in the most recent edition of the American Psychiatric Associations' Diagnostic and Statistical Manual of Mental Disorders (DSM) that substantially limits the functioning of the person with the condition up to and including:

- Affective disorders
- Autism (see Autism Spectrum Disorder Benefit);
- Bipolar Disorder;
- Delirium;
- Dementia
- Eating Disorders;
- Major depressive Disorder
- Obsessive-Compulsive Disorder;
- Panic Disorder
- Paranoia and other psychotic disorders;
- Post Traumatic Stress Disorder;
- Schizoaffective Disorder;
- Schizophrenia;
- Substance Abuse Disorders; and
- any Biologically-Based Mental Disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association that are scientifically recognized and approved by the commissioner of the department of mental health in consultation with the commissioner of the division of insurance.

Coinsurance: means the out-of-pocket expenses to be paid by the Covered Person as a percentage of the Covered medical Expenses as show in the Schedule of Medical Benefits.

Co-payment (Co-pay): means a fee charged to the Covered Person at the point the service is rendered or prescription is dispensed.

Covered Medical Expense: means charges for medically necessary treatment, services, or supplies received by an individual while enrolled in this plan. Covered charges may not be in excess of Preferred Allowance, Negotiated Fee, Reasonable and Customary expenses or in excess of charges that would be made in the absence of this insurance. Such expenses will be subject to the terms listed in the schedule of benefits and detailed in the covered benefits section.

Covered Person: means an individual that is covered under this Plan as either the Covered Student or as an eligible Dependent of the Covered Student.

Covered Student: means a student of the Plan Sponsor who has paid the applicable premium for coverage and is enrolled in the SHBP.

Deductible: means the dollar amount of Covered Medical Expenses that the Covered Person must incur as an out-of-pocket expense each Policy Year before benefits are payable under this Policy. The Deductible amount, as shown in the Schedule of Medical Benefits, may be reduced or waived under certain conditions. Most of such conditions are specified in the Schedule of Medical Benefits.

Eligible Dependent: means one of the following persons:

(1) A child of the Covered Student who has not attained 26 years of age;
(2) A person who is the lawful spouse of the Covered Student;
(3) A person for whom the covered student has completed and signed a "declaration of domestic partnership";
(4) An unmarried child of the Covered Student who is age 26 or older and is permanently and totally disabled (under Internal Revenue code Section 22 (e)(B)).

For purposes of determining eligibility, the term "child" means:

- any person under age 26 for whom the Covered Student must provide coverage under a child support order;
- any person who resides with the Covered Student for more than half the taxable year and for whom the Covered Student ;is appointed legal guardian by a court of competent jurisdiction
- a Covered Student's step-child, biological child, legally adopted child or child placed with the Covered Student for adoption; or
- any child of the Covered Student's Domestic Partner who would otherwise qualify as a Child of the Covered Student under this section if the Domestic Partner and the Student were legally married to each other; provided, however, that the Child must reside with the Student or Domestic Partner Participant.

Elective Treatment: medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes; but is not limited to:

- vasectomy;
- breast reduction;
- submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis;
- treatment for weight reduction;
- learning disabilities;
- temporamandibular joint dysfunction (TMJ).

Emergency Medical Condition: means medical condition that manifests itself by symptoms of sufficient severity, that could lead a reasonably prudent layperson with an average knowledge of health and medicine, to believe that lack of prompt medical attention could place the health of a Covered Person in serious jeopardy, serious impairment to body function, serious dysfunction of any body organ or part, or, with respect to a pregnant woman, may cause distress to the fetus.

Emergency Medical Care: means immediate medical intervention to prevent death or serious impairment of the health of the Covered Person.

Essential Health Benefits: Has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services, and includes the following categories of Covered Services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (in accordance with the applicable state or federal benchmark plan).

Filing date or the equivalent: means the earlier of (a) 5 days after the date of mailing or (b) the date of receipt.

Hospital: means a health care facility that:

- Primarily engaged to provide in-patient services for a fee for the treatment of Injured and sick people;
- Has established facilities for diagnosis and major surgery under the supervision of a physician (s) who is(are) legally licensed to practice medicine;
- Is licensed and run as a hospital according to the laws and regulations applicable to the location/jurisdiction including the Joint Commission on Accreditation of Health Care Organizations, and accredited by the Commission of Accreditation of Rehabilitation Facilities.

Hospital Confinement: means a stay of eighteen (18) or more hours in a row of care as a patient in a hospital.

Illness: means a disorder or disease either or the body or a mental nervous disorder including reoccurring symptoms of the same illness. In this document the term Illness and Sickness are used interchangeably.

All conditions due to the same or related illness are considered one illness. The term Illness/Sickness includes pregnancy, and complications of pregnancy.

Injury/Injuries: means physical harm to the body due to an accident, trauma, or damage that includes complications arising from an injury due to an accident but is independent of all other causes including illnesses.

In-Network: means an organization, Hospital, Physician, Practitioner, or other Provider that has agreed to participate in the Preferred Provider Network and accept a Negotiated Charge for their services. That negotiated charge, known as the preferred provider amount (PA), is the maximum charged a provider in the network for their service or supply under this plan.

Johns Hopkins University Counseling Center: a clinic operated; maintained; and supported by the school that provides counseling services to enrolled students.

Johns Hopkins University Student Heath & Wellness Center: a clinic operated; maintained; and supported by the school that provides health care services to enrolled students.

Georgetown University Student Health Center: a clinic operated; maintained; and supported by the school that provides health care services to enrolled students.

Medically Necessary: means a service or supply that is not experimental or investigational and is necessary and appropriate for the diagnosis or treatment of an Injury or Illness base on generally accepted current medical practices.

For a treatment, service or supply to be considered medically necessary, the service or supply must, without creating a negative impact on the overall health of the Covered Person, be:

- Care or treatment likely to produce a significant positive outcome both to the sickness or injury involved and to the overall health of the Covered Person without being more costly than any other comparable care or treatment; or
- A diagnostic procedure likely to result in producing information that could affect the course of treatment in a way other less costly diagnostic procedures could not do; and
- Ordered by a treating physician; safe and effective in treating the condition for which it is ordered; of the proper quantity, frequency, and duration for the treatment of the condition for which it is ordered; and applied according to practices generally accepted by the American Medical Community.

In determining if a service or supply is appropriate under the circumstance, the Claim Administrator will take all pertinent information into account such as:

- Information relating to the health status of the Covered Person;
- Reports in peer reviewed medical literature;
- Reports and guidelines, including scientific data, published by nationally recognized health care organizations;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis care or treatment; and
- The opinion of health care professional in the generally recognized health field specifically involved.

Medically Necessary will never include: services that do not require the technical skills of a medical, mental health or dental professional; or service furnished mainly for the personal comfort or convenience of the Covered Person or any person who is caring for the Covered Person; services furnished solely because the person was inpatient on a day which there person's covered medical condition could safely and adequately be diagnosed or treated on an outpatient basis or other less costly setting.

Out-of-Pocket: means the most You will pay during a Policy Year before your coverage pays at 100%. This includes deductibles, copayments (medical and prescription) and any coinsurance paid by You. This does not include non-covered medical expenses and elective services.

Out-of-Network: means an organization, Hospital, Physician, Practitioner, or other Provider that has not agreed to participate in the Preferred Provider Network.

Physician: means a practitioner of the healing arts that is legally qualified and recognized by the state in which he or she practices. Such practitioners include but are not limited to: Doctor of Medicine (M.D.), Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Licensed Anesthesiologist, Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed. D., Psy.D., MA), Registered Nurse (R.N.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Speech Therapist, Occupational Therapist, Physician's Assistant, Registered Respiratory Therapist, Nutritionist, Nurse Practitioner (A.R.N.P.), or Naturopath (N.D.).

Reasonable and Customary Charges (R&C): means most common charge for similar professional service, procedures, drugs, devices, supplies or treatment within the geographical area where the covered medical expense was incurred. The most common charge means the lesser of:

- The actual amount charged by the provider; or
- The negotiated rate; or
- The charge which would have been made by the provider (Doctor, Hospital, etc.) for a comparable service or supply made by other providers in the same Geographic Area, as reasonable determined by us for the same service or supply.

As used in this plan: "Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Sickness: means either a disorder or disease of the body including reoccurring symptoms of the same illness. In this document the term Illness and Sickness are used interchangeably. All conditions due to the same or related sicknesses are considered one sickness. The term Illness/Sickness includes pregnancy, and complications of pregnancy.

We, Our or Us: means the Claim Administrator on behalf of the Johns Hopkins University SHBP.

You, Your, Yours means the Covered Person.

Male pronouns whenever used include female pronouns.

Schedule B
HIPAA Privacy Trained Employees

The following persons have been designated by the Sponsor as authorized to use or disclose Protected Health Information ("PHI") for purposes of the Plan and have received appropriate training regarding the Plan's Health Information Privacy Policies and Procedures and the applicable requirements of the Privacy Regulations. Any person on this list is authorized to access PHI on behalf of the Plan beginning on the date training has been completed and ending on the date that he or she is no longer authorized to access PHI (e.g., because of termination of employment or a change in responsibilities).

Name	Date training completed	Date no longer authorized to access PHI