For the most current information regarding the SHBP, refer to the SHBP web site at: Johns Hopkins University sis.jhu.edu (Personal Info>Health Insurance)
# TABLE of CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>3</td>
</tr>
<tr>
<td>GENERAL INFORMATION</td>
<td>5</td>
</tr>
<tr>
<td>SHBP ELIGIBILITY</td>
<td>6</td>
</tr>
<tr>
<td>SCHEDULE OF BENEFITS</td>
<td>10</td>
</tr>
<tr>
<td>COVERED MEDICAL SERVICES</td>
<td>14</td>
</tr>
<tr>
<td>PREADMISSION/PRECERTIFICATION/CASEMANAGEMENT</td>
<td>35</td>
</tr>
<tr>
<td>EXCLUSIONS</td>
<td>37</td>
</tr>
<tr>
<td>COORDINATION OF BENEFITS</td>
<td>39</td>
</tr>
<tr>
<td>WHEN COVERAGE ENDS</td>
<td>40</td>
</tr>
<tr>
<td>DEFINITIONS</td>
<td>42</td>
</tr>
<tr>
<td>PROCEDURE/STATEMENT OF RIGHTS</td>
<td>46</td>
</tr>
</tbody>
</table>
INTRODUCTION

This document has been prepared by the Plan Sponsor for Students that are enrolled in the Johns Hopkins University Student Health Benefit Plan (SHBP). This health plan is a partially self-funded health benefits plan funded by the Plan Sponsor. The Claims Administrator has been designated by the Plan Sponsor to provide administrative services for the SHBP either directly or through contracting with an appropriate agency. Please take a few minutes to carefully read this document as it is designed to help the Covered Person understand their medical and prescription drug benefits. An overview of your coverage can be found in the Schedule of Benefits.

Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

This is a Preferred Provider Organization (PPO) health plan. That means each Covered Person has the ability to control the costs that each will pay when they choose a provider to furnish their covered medical care.

Certain conditions and limitations affect the benefits you receive under the SHBP. We hope to help make you a wise consumer of health services and use only the services you need. Please be aware, even if your health care practitioner recommends them, not all kinds of treatments or services qualify as Covered Medical Expenses under the SHBP.

Please note that while most medical services charges are paid quickly, a few may require additional information from you or your provider before a payment is processed. If the Claims Administrator requests additional information please respond quickly; failure to do so may result in non-payment from SHBP and you will be responsible for the charge.

Please contact the Claims Administrator: Consolidated Health Plans, toll free (877) 657-5044 if you have any questions about your coverage. Please make note of the following elements of the SHBP:

1. Preferred Provider Organization (PPO) Network Health Plan
   Benefits under this plan consist of two (2) levels:
   - One for in-network benefits provided by another PPO Provider;
   - One for out-network benefits.
   The chosen Preferred Provider Network is a group of Physicians, Practitioners, and Hospitals who have contracted to accept a negotiated fee for their services. The costs you pay for Covered Medical Expenses will differ based on the benefit level and where the care is received. To receive the highest benefit level, obtain your health care services and supplies from providers who participate in your PPO health care network. If you choose to obtain your health care services and supplies from a non-participating provider, you will usually receive the lowest level of benefit; that is you will have higher out-of-pocket charges.

   The Cigna PPO network of Participating Providers is available at [www.cigna.com](http://www.cigna.com) or contact Consolidated Health Plans toll free at (877)-657-5044, or for assistance.

2. Pre-certification of care
   The Schedule of Benefits identifies medical Covered Services which must be Pre-Certified by the Review Organization. Advising the Review Organization before you receive such medical Covered Services allows the Review Organization to determine Medical Necessity and Medical
Appropriateness. Medical care that is not necessary and appropriate adds to the cost of care and exposes you to unnecessary risk.

You are responsible for calling the Review Organization at the phone number found on the Your ID card and starting the Pre-Certification process. For Inpatient services, the call should be made prior to Hospital Admission. In the case of an Emergency, the call should take place as soon as reasonably possible.

Pre-Certification is not required for Medical Emergency, Urgent Care, or Hospital Admission for maternity care.

Pre-certification is not a guarantee that Benefits will be paid.

Your Physician will be notified of the Review Organization’s decision as follows:

- For elective (non-Emergency) admissions to a Health Care Facility, the Review Organization will notify Your Physician and the Health Care Facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
- For Admission in a Health Care Facility longer than the originally approved number of days, Your treating Physician or the Health Care Facility must contact the Review Organization before the last approved day. The Review Organization will review the request for continued stay to determine Medical Necessity and notify the Physician or the Health Care Facility of its decision in writing or by telephone.

Our Review Organization agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. Notice of an adverse determination made by the Review Organization agent will be in writing and will include:

- The reasons for the adverse determination including the clinical rationale, if any.
- Instructions on how to initiate standard or urgent appeal.
- Notice of the availability, upon request of the Covered Person, or the Covered Person’s designee, of the clinical review criteria relied upon to make the adverse determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, the Review Organization Agent in order to render a decision on any requested appeal.

Failure by the Review Organization agent to make a determination within the time periods prescribed shall be deemed to be an adverse determination subject to appeal.

If You have questions about Your Pre-Certification status, You should contact Your Provider. 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. For further details please review the Preadmission/Precertification section as listed in the table of contents.

**Impact of the Affordable Care Act (ACA)**

The Plan Sponsor has elected to voluntarily configure the benefits of the 2016-2017 plan year to comply with the regulations issued by the U.S. Department of Health and Human Service (HHS) as required by the Affordable Care Act (ACA) for fully insured student health insurance programs.

**NOTE:** This brochure is provided as a courtesy and is not meant to replace or override the terms and conditions detailed in the Plan Document. Please refer to the Plan Document for more detailed information.
## GENERAL INFORMATION

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Johns Hopkins University Student Health Benefits Plan (SHBP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of Plan</td>
<td>Non-ERISA governed student health benefits plan providing medical and prescription drug benefits on a partially self-funded basis.</td>
</tr>
<tr>
<td>Effective</td>
<td>Effective August, 15, 2016</td>
</tr>
<tr>
<td>*Carey Business School has Early Arrivals effective 7/11/2016</td>
<td></td>
</tr>
<tr>
<td>Plan Sponsor</td>
<td>Johns Hopkins University</td>
</tr>
<tr>
<td>3400 N. Charles Street</td>
<td></td>
</tr>
<tr>
<td>Baltimore, MD 21218</td>
<td></td>
</tr>
<tr>
<td>Group Number</td>
<td>S210314</td>
</tr>
<tr>
<td>Plan Administrator</td>
<td>Johns Hopkins University</td>
</tr>
<tr>
<td>Claim Administrator</td>
<td>Consolidated Health Plans</td>
</tr>
<tr>
<td>2077 Roosevelt Avenue</td>
<td></td>
</tr>
<tr>
<td>Springfield, MA 01104</td>
<td></td>
</tr>
<tr>
<td>877-657-5044</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.consolidatedhealthplan.com">www.consolidatedhealthplan.com</a></td>
<td></td>
</tr>
<tr>
<td>In-Network Providers</td>
<td>Cigna PPO Network of Participating Providers</td>
</tr>
<tr>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
<td>(877) 657-5044</td>
</tr>
<tr>
<td>Prescription Benefits Administrator</td>
<td>Cigna Pharmacy Plan</td>
</tr>
<tr>
<td><a href="http://www.cigna.com">www.cigna.com</a></td>
<td>(877) 657-5044</td>
</tr>
<tr>
<td>Case Management Services</td>
<td>Hines and Associates</td>
</tr>
<tr>
<td>(800) 670-7718</td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation and Repatriation Provider</td>
<td>Travel Guard</td>
</tr>
<tr>
<td>Termination and/or Modification</td>
<td>The Plan Sponsor may terminate the SHBP at the end of any Plan Year, or change the provisions of the SHBP at any time by a written Plan Document amendment signed by a duly-authorized officer of The Plan Sponsor. The consent of any Covered Person is not required to terminate or change the SHBP.</td>
</tr>
</tbody>
</table>
SHBP ELIGIBILITY

A. STUDENT ELIGIBILITY
All full-time registered domestic students are required to purchase the Student Health Benefit Plan unless proof of comparable coverage is furnished. All International students are required to enroll in the Student Health Benefit Plan. All students enrolled in part-time programs, non-resident Graduate students, and Graduate study abroad students are eligible to enroll in the Student Health Benefit Plan.

The Enrollment/Waiver Form should be submitted prior to registration but no later than September 15, 2016 for Arts and Sciences and Engineering and SAIS (Washington and Nanjing) students.

For Carey Business School, Peabody Students and SAIS (Bologna) students, the Fall Semester waiver deadline is September 30, 2016.

ENROLLMENT
To Enroll or Waive Online:

- Johns Hopkins University sis.jhu.edu (Personal Info>Health Insurance)
- Simply follow the prompts on the screen by providing all information requested.

WAIVER PROCESS/PROCEDURE
Eligible students will be automatically enrolled in this plan, unless the completed Waiver Form has been received by the University, by the specified enrollment deadline dates listed in the next section of this Brochure.

<table>
<thead>
<tr>
<th>Category</th>
<th>Waiver Deadline Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students attending for the Fall Semester</td>
<td>9/15/2016</td>
</tr>
<tr>
<td>Students attending for the Spring Semester</td>
<td>2/15/2017</td>
</tr>
</tbody>
</table>

Please note: For Carey Business School, Peabody Students and SAIS (Bologna) students, the Fall Semester waiver deadline is September 30, 2016.

REFUND POLICY
If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Plan and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Exception: A Covered Person entering the armed forces of any country will not be covered under the Plan as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any covered dependents upon written request received by Consolidated Health Plans within 90 days of withdrawal from school.
B. DEPENDENT COVERAGE

ELIGIBILITY
Covered Students may also enroll their lawful spouse, and children under age 26. At the request of the Plan Sponsor, the Plan shall provide the same health benefits and eligibility guidelines that apply to any covered dependent to a domestic partner or a child dependent of the domestic partner of the Covered Person. The definition of a dependent child of a domestic partner is the same as the definition of a dependent child of the covered person except that the domestic partner’s child must live with the covered person. See the definition of Eligible Dependent.

ENROLLMENT FOR DEPENDENTS
To Enroll a dependent:
- www.chpstudent.com
- Simply follow the prompts on the screen by providing all information requested.

NEWBORN INFANT AND ADOPTED CHILD COVERAGE
A child born to a Covered Person shall be covered for Accident, Sickness, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the Johns Hopkins University Student Health Benefit Plan. To extend coverage for a newborn past the 31 days, the Covered Student must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

Coverage is also provided for an adopted child who meets the definition of a dependent child as of the date the child is “placed for adoption” with the Covered Student (this means the assumption and retention of a legal obligation for total or partial support of the child in anticipation of adoption of the child), or a child for whom guardianship is granted by a court or testamentary appointment, from the date the child is placed for adoption, the date of appointment or the date the grandchild is placed in custody for an initial period of 31 days. To continue the benefit plan beyond this initial 31 day period, the Covered Person must notify Johns Hopkins University or Consolidated Health Plans of the placement, adoption or custody of such child, and pay any additional premium required for the child’s benefits within the 31 day period.

For information or general questions on dependent enrollment, or to enroll your dependent, contact Consolidated Health Plans, Inc. (877) 657-5044.

Late Enrollment:
This section provides an option for Students, under certain circumstances, to be approved to enroll in the SHBP after the otherwise applicable enrollment deadline has passed.

a. If a student originally waived coverage under this SHBP plan, and later due to a qualifying life event, lost eligibility under that plan, the student will be considered a Late Enrollee under this plan. Such late enrollee must make a request for enrollment within thirty (30) days of loss of coverage and provide documentation showing the exact date the prior coverage will expire. A student enrolling late but within that thirty (30) day time frame may also enroll Eligible Dependents. If an approved Student’s request for coverage is made and applicable premium paid within the aforementioned 30 day deadline, coverage under the SHBP will begin the day after the prior coverage ends.
b. An eligible student who waived SHBP but for whom it is discovered does not have insurance coverage that meets requirements for comparability will be enrolled and billed for SHBP. Benefits
for such students will begin the first of the month following enrollment in SHBP.
c. An exception to that rule exists in the case of a Student who is under a court order (Qualified Medical Child Support Order) requiring the Student to provide coverage for his or her eligible dependent. In such a case, the dependent’s effective date under the plan will be the effective date of the court order. Applicable premiums for the semester/plan year will apply.

MEDICAL LEAVE OF ABSENCE
A JHU student who goes on Medical Leave of Absence (MLOA) on or after the first day of fall classes is eligible to stay on the plan for the remainder of the plan year which ends August 14th and to purchase 3 months of additional coverage.
A student who goes on MLOA during the Fall term is still eligible to purchase coverage for the Spring term and for the three months following the end of the plan year should they still be on Medical Leave of Absence.

REFERRAL REQUIREMENTS
Full-Time Arts and Sciences, Engineering and Peabody students have access to the Counseling Center and Student Health and Wellness Center located on the Homewood Campus and should first seek care at one of these two Centers. Students in the School of Advanced International Studies should first seek medical care at the Georgetown University Health Center. Your Deductible will be reduced if you initiate treatment at these facilities; please refer to the Schedule of Medical Benefits for details. Dependents are not eligible to use the services of the Johns Hopkins University Student Health and Wellness Center or the Counseling Center and are not eligible for this referral service and are therefore subject to the Plan Deductible listed in the Schedule of Medical Benefits.

Please note: Referrals will not be issued retroactively.

Students’ health care needs can best be satisfied and costs contained when student health centers manage students’ primary care treatment, and provide a referral to outside care if needed. A referral is not needed in the case of an Emergency Medical Condition or for obstetrical (including care related to pregnancy) and gynecological services. The Plan covers one well-woman visit per Policy Year, which includes the office visit, Pap smear, and Chlamydia screening. (Please Note: The Student Health and Wellness Center offers comprehensive gynecological services including annual exams. Out-of-pocket expenses may be reduced by initiating care at the Student Health Center.)

If you need continuing care from a specialist for one of these services, you may request that a “standing referral” be given for your continuing care for this treatment.

Please Note: The Counseling Center and Student Health and Wellness Center will not refer students who are not eligible for treatment at the Counseling Center or Student Health and Wellness Center. Johns Hopkins Student Assistance Program (JSAP) Mental Health providers are available for those students that do not have access to the Counseling Center at the ASEN Campus. Dependents and students enrolled in the following divisions (SAIS, Carey Business School and School of Education, Arts and Science Advanced Academic Programs (AAP), and Engineering and Applied Science Programs for Professionals (EPP)) are not eligible for services at the Student Health and Wellness Center or Counseling Center.
Contact Information and questions about Student Health & Wellness Center and Counseling Center referrals:

Full-Time Arts & Sciences and Engineering Students
Student Health and Wellness Center: (410) 516-8270
1 East 31st Street, N-200, Baltimore, MD 21218

Peabody Students
Student Health and Wellness Center: (410) 516-8270
1 East 31st Street, N-200, Baltimore, MD 21218

Johns Hopkins University Counseling Center
3003 North Charles Street, Suite S-200, Baltimore, Maryland 21218
Telephone: 410-516-8278

School of Advanced International Studies (SAIS) Students
Johns Hopkins Student Assistance Program: (866) 764-2317
Washington, DC
Georgetown University Student Health Center: (202) 687-2200
Darnall Hall, Ground Floor 3800 Reservoir Rd. NW, Washington, DC 20007

NOTE: Engineering for Professionals, Carey Business School, SAIS and School of Education students have access to and should contact the Johns Hopkins Student Assistance Program located on the Homewood Campus: (443)287-7000

Students who are enrolled in Carey Business School, School of Education, AAP (Advanced Academic Programs), EP (Engineering for Professionals) do not have access to the Student Health & Wellness Center, the Counseling Center, or the Georgetown University Student Health Center, therefore benefits for these students will be subject to the Deductible as listed in the Schedule of Medical Benefits.

Dependents are not eligible to use the services of the Student Health & Wellness Center, the Counseling Center, or the Georgetown University Student Health Center and are therefore not subject to the referral requirements and penalties.

A referral is not required in the following circumstances:
- Treatment is for an Emergency Medical Condition,
- Obstetric and Gynecological Treatment,
- Pediatric Care,
- Preventive/Routine Services (services considered preventive according to the regulations issued by the U.S. Department of Health and Human Service (HHS) as required by the Affordable Care Act (ACA)}
### INPATIENT HOSPITALIZATION BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room and Board Expense</td>
<td>80% of Preferred Allowance (PA)</td>
<td>64% of Reasonable and Customary Charges (R&amp;C)</td>
</tr>
<tr>
<td>Miscellaneous Hospital Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>In-Hospital Non-Surgical Physician Expenses</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
</tbody>
</table>

### Pre-certification

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.

<table>
<thead>
<tr>
<th>SURGICAL BENEFITS (INPATIENT AND OUTPATIENT)</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical Expense. Expenses incurred for a surgical services, performed by a Physician.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Anesthesia Expense. Charges of anesthesia during a surgical procedure.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Assistant Surgeon Expense. Charges of an assistant surgeon during a surgical procedure.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>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.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Pre-Admission Testing Expense. Charges incurred while outpatient before scheduled surgery</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Surgical Second Opinion Expense</td>
<td>100% of PA</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Acupuncture in Lieu of Anesthesia Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPATIENT BENEFITS</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Hospital Outpatient Department</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Walk-In Clinic Visit Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Emergency Room Expense. Charges for treatment of an Emergency Medical Condition.</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>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 $250 Deductible.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Expense. Charges for an urgent care provider to evaluate and treat an urgent condition.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>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 illness.</td>
<td>80% of Actual Charge</td>
<td></td>
</tr>
<tr>
<td>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).</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Laboratory and X-ray Expense. Includes diagnostic services, laboratory and x-ray examinations.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>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.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Therapy Expense. Includes Physical Therapy, Chiropractic Care, Speech Therapy, Cardiac Rehabilitation, Inhalation Therapy, Occupational Therapy, Radiation Therapy, Chemotherapy, Dialysis and Respiratory Therapy.</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Durable Medical Equipment Expense</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>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.</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Dental Injury Expense. For injury to sound natural teeth.</td>
<td>80% of Actual Charge</td>
<td></td>
</tr>
<tr>
<td>Impacted Wisdom Teeth Expense. For removal of one or more impacted wisdom teeth.</td>
<td>80% of Actual Charge</td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>----------------</td>
</tr>
<tr>
<td><strong>General Anesthesia for Dental Care Expense</strong></td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>**Allergy Testing and Treatment Expense. Includes charges incurred by</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>a covered person for diagnostic testing and treatment of allergies and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>immunology services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MENTAL HEALTH BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Illness Inpatient/Outpatient Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Substance Abuse Inpatient/Outpatient Expense. Includes inpatient</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>and intermediate treatment services for substance abuse.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing for Attention Disorders and Learning Disabilities</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Expense. Includes Diagnostic testing for attention deficit disorder or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>attention deficit hyperactivity disorder.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MOTHERY BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Expense / Newborn Nursery Care. Includes pregnancy,</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>complications of pregnancy, childbirth, other pregnancy-related</td>
<td></td>
<td></td>
</tr>
<tr>
<td>expenses and inpatient care of the covered person and any newborn</td>
<td></td>
<td></td>
</tr>
<tr>
<td>child for a minimum of 48 hours after a vaginal delivery and for a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>minimum of 96 hours after a cesarean delivery.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal Care and Comprehensive Lactation Support. Includes services</td>
<td>100% of PA</td>
<td>84% of R&amp;C</td>
</tr>
<tr>
<td>received by a pregnant female in a physician’s, obstetrician’s or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>gynecologist’s office and lactation support and counseling services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>provided to females during pregnancy and in the post-partum period by</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a certified lactation support provider.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Feeding Durable Medical Equipment Expense. Includes the</td>
<td>100% of PA</td>
<td>84% of R&amp;C</td>
</tr>
<tr>
<td>rental or purchase of breast feeding durable medical equipment for the</td>
<td></td>
<td></td>
</tr>
<tr>
<td>purpose of lactation support (pumping and storage of breast milk).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>ADDITIONAL BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellness/Preventive and Immunizations Expenses. Includes but is</td>
<td>100% of PA</td>
<td>84% of R&amp;C</td>
</tr>
<tr>
<td>not limited to: Routine Physicals, Preventive Care Visits, Laboratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services, Immunizations (including titers) &amp; Vaccines, GYN exams,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prostate exam and Routine Prostate Cancer Screening. (For more</td>
<td></td>
<td></td>
</tr>
<tr>
<td>information, please visit: <a href="http://www.healthcare.gov/prevention">www.healthcare.gov/prevention</a>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap Smear Screening Expense</td>
<td>100% of PA</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Mammogram Expense Testing Expense</td>
<td>100% of PA</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Diabetic Supplies &amp; Outpatient Diabetic Self-Management Education</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Prescription Special Medical Formulas Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td><strong>ADDITIONAL BENEFITS (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Prescription Enteral Formula Expense. Includes treatment of</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>malabsorption caused by the following:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Crohn’s Disease,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ulcerative Colitis,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Gastroesophageal Reflux, Gastrointestinal Motility,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Chronic Intestinal Pseudoobstruction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inherited diseases of amino acids and organic acids.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Foods and Modified Food Products Expense. Includes medical</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>foods and low protein modified food products for the treatment of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>inherited metabolic disease when authorized by, and administered under</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the direction of, a Physician.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care Expense</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Hospice Care Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Hormonal testing</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Transfusion or Dialysis of Blood Expense. Includes the cost of whole</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>blood, blood components and the administration thereof.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefit</td>
<td>Payable as (%)</td>
<td>Payable as (%)</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>----------------</td>
<td>----------------</td>
</tr>
<tr>
<td>Licensed Nurse and Consulting Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Skilled Nursing Facility Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Rehabilitation Facility Expense</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Cleft Lip/Cleft Palate Treatment Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Clinical Trial Costs Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Speech, Hearing and Language Disorders Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Habilitative Services Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Early Intervention Services Expense</td>
<td>100% of PA</td>
<td>100% of R&amp;C</td>
</tr>
<tr>
<td>Outpatient In Vitro Fertilization/Infertility Expense</td>
<td>Payable on the same basis as any pregnancy-related procedure</td>
<td></td>
</tr>
<tr>
<td>Outpatient Contraceptive Drugs, Devices and Family Planning Services Expense</td>
<td>100% of PA</td>
<td>84% of R&amp;C</td>
</tr>
<tr>
<td>Alzheimer's Disease Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Hearing Aid Expense. This benefit is limited to one hearing aid for each impaired ear, every 36 months</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Routine Vision Care for Children under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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, Aphasis, 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, with a maximum charge of $300; maximum low vision aid allowance of $600 with a lifetime maximum of $1,200 for items such as high-power spectacles, magnifiers and telescopes; and follow-up care – four visits in any five year period, with a maximum charge of $100 each visit. Precertification is required for all low vision services.</td>
<td>100% of PA</td>
<td>84% of R&amp;C</td>
</tr>
<tr>
<td>Dental Care for Children under age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive</td>
<td>100% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Basic Dental Care</td>
<td>70% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Major Dental</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Endodontics, Periodontics and Prosthodontics)</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>Orthodontics</td>
<td>50% of R&amp;C</td>
<td></td>
</tr>
<tr>
<td>(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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scalp Hair Prosthesis</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Coverage for Bones of Face, Neck and Head Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Reconstructive Breast Surgery, Post Hospitalization and Mastectomy Prosthetic Devices Expense</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
<tr>
<td>Treatment of Morbid Obesity Expense</td>
<td>Payable on same basis as any other surgical procedure</td>
<td></td>
</tr>
<tr>
<td>Assessment of Metabolic Risk (in a patient whose Body Mass Index (BMI) is 25 kg/m² or greater to include: (1) fasting lipid profile, (2) TSH, (3) liver enzymes, and (4) a fasting glucose or hemoglobin A1C level</td>
<td>80% of PA</td>
<td>64% of R&amp;C</td>
</tr>
<tr>
<td>Prosthetic and Orthopedic Devices Expense</td>
<td>80% of PA</td>
<td>80% of R&amp;C</td>
</tr>
<tr>
<td>Transgender Surgery Expenses up to $100,000 per plan year maximum (non-surgical benefits payable as any other condition)</td>
<td>Payable as any other Covered Medical Expense</td>
<td></td>
</tr>
</tbody>
</table>
**PRESCRIPTION DRUG BENEFIT**

**At SH&W**

**In-Network**

**Out-of-Network**

<table>
<thead>
<tr>
<th>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.</th>
<th>$8 SH&amp;W co-pay per prescription</th>
<th>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</th>
<th>100% of R&amp;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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three (3) month supply at retail pharmacy available for two (2) copays.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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/proguanil) are also covered and do not require prior authorization.

<table>
<thead>
<tr>
<th></th>
<th>100%</th>
<th>80% of PA</th>
<th>64% of R&amp;C</th>
</tr>
</thead>
</table>

**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 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.
- The Accident causing the covered injury must occur while the Covered Person is covered under this plan.
- Treatment is initiated/completed within one (1) calendar year of the Accident.

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 spontaneous and non-elective 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 NCI 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 experience and training, and treat a sufficient volume of patients to maintain that expertise.

i. **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.
I. 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
Coverage is provided for Covered Persons under the age of nineteen (19) years. 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 same-sex 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) and in vitro fertilization and embryo placement (IVF).

Outpatient In Vitro Fertilization Expense

Includes expenses incurred by a female student, or by the dependent wife of a male student for outpatient in vitro fertilization procedures. They will be included on the same basis as for sickness, but only if the following conditions are met:
- The procedures are performed while she is not confined in a Hospital or any other facility as an inpatient.
- Her oocytes are fertilized with her husband’s sperm.
- She and her husband have a history of infertility. It must have lasted at least 2 years, 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
• She 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

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867. If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 or if you are in a foreign country, call collect at: 715.295.9311. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

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).

2. 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.

c. 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, ketone 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 autologous blood and blood plasma. Expenses for storage of autologous blood or blood plasma will not be covered.)

II. 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;
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 Claim Administrator 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 the Claim Administrator.

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). Notwithstanding 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). Expenses incurred for gynecomastia 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 incurred for voluntary or elective abortions.

27. Expenses for charges for or related to artificial insemination; elective sterilization or its reversal or elective abortion unless specifically provided for in this Plan.

28. Expenses for acupuncture unless otherwise specifically covered under the Plan.

29. Expenses for alternative, holistic medicine, and or therapy; including but not limited to yoga, and hypnotherapy.

30. Expenses for massage therapy.

31. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the Plan.

32. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

33. 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.

34. 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.

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.

WHEN COVERAGE ENDS
This plan provides for Covered Medical Expenses of the Covered Person only while their coverage under the SHBP is in force. Except as provided in the Extension of Benefits provision, this SHBP will pay no benefits incurred after the Covered Person’s coverage ends.

TERMINATION OF STUDENT COVERAGE
Coverage for a Covered Student will end on the first of these to occur:

a. the premium date coinciding with or next following the date this Plan terminates,
b. the last day for which any required premium has been paid,
c. the date on which the covered student withdraws from the school because of entering the armed forces of any country. Contributions will be refunded on a pro-rata basis, as applicable.

If withdrawal from school is for other than entering the armed forces, no premium refund will be made. Students will be covered for the Plan term for which they are enrolled, and for which premium has been paid.

Termination will not prejudice any claim beginning before the date coverage ends for a Covered Medical Expense.

TERMINATION OF DEPENDENT COVERAGE
Coverage for a Covered Student’s dependent will end when insurance for the Covered Student ends. Coverage will continue during scholastic vacations if the student was insured on the day before such vacation began. Before then, coverage will end:

a. For a child, on the last day of the Plan period following the child’s 26th birthday.
b. The date the Covered Student fails to pay any required premium.
c. For the spouse, the date the marriage ends in divorce or annulment.
d. The date dependent coverage is deleted from this Policy.
e. For a domestic partner, the earlier to occur of:
   • the date this Plan no longer allows coverage for domestic partners, and
   • on the contribution due date the date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to the Plan.
f. On the contribution due date the date the dependent ceases to be in an eligible class.

Termination will not prejudice any claim beginning before the date coverage ends for a Covered Medical Expense.

INCAPACITATED DEPENDENT CHILDREN
Coverage may be continued for incapacitated dependent children who reach the age at which coverage would otherwise cease. The dependent child must be chiefly dependent for support upon the Covered Student and be incapable of self-sustaining employment because of mental or physical handicap.

Due proof of the child's incapacity and dependency must be furnished to Johns Hopkins University by the Covered Student within 31 after the date coverage would otherwise cease. Such child will be considered an Eligible Dependent, so long as the Covered Student submits proof to Johns Hopkins University, Plan Administrator, at reasonable intervals during the two (2) years following the child's attainment of the limiting age and each year thereafter, that the child remains physically or mentally unable to earn his own living. The contribution due for the child's coverage will be the same as for a child who is not so
incapacitated.

The child’s coverage under this provision will end on the earlier of:
   a. the date specified under the provision entitled Termination of Dependent Coverage, or
   b. the end of the term for which contribution has been paid on or after the date the child is no longer incapacitated and dependent on the Covered Student for support.

A. Extension of Benefits
   If, on the termination date, a Covered Person is Totally Disabled, charges will continue to be honored for a period of 12 months following termination of insurance or the date the individual is ceases to be Totally Disabled, whichever is earlier.
   If, on the termination date, a Covered Person is confined to a hospital due to a Covered Injury or Sickness, charges for that confinement will continue to be honored for a period of 12 months following termination of insurance or the date the individual is discharged from the hospital, whichever is earlier. Charges for medical expenses incurred within that time frame will not be covered if not related to the injury or illness causing the need for hospital confinement.

B. Certificate of Creditable Coverage
   In the event a Covered Person loses coverage under the SHBP, the Plan Administrator will provide a Certificate of Coverage to the individual no longer covered by the SHBP. As mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), such Certificate of Coverage must be requested within 24 months of the Covered Person losing coverage under the SHBP.

DEFINITIONS

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 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 person who has attained 26 years of age, but is permanently and totally disabled (as defined by Internal Revenue code Section 22 (e)(B)).

For purposes of determining eligibility, the term child includes:
- An individual under age 26 for whom the Student is required to provide coverage due to a Qualified Medical Child Support Order;
- A child for whom legal guardianship has been awarded to the Student. The child must live with the Student in a parent-child relationship for more than half of the taxable year;
- A legally adopted child;
- A child placed with the Student for adoption by a court with adequate jurisdiction;
- A stepchild by legal marriage; or
- A biological child of the Student.

NOTE: If proof of domestic partner relationship is required then the proof requested must comply with MD regulation ADC 31.10.35-01 through 03. Domestic partner includes same and opposite sex per MD regulation.

**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;
- temporomandibular 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).

**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 Health & 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 based 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 sickneses 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.

PROCEDURE/STATEMENT OF RIGHTS

A. Claims Procedures

The investigation and adjudication of claims will be handled by the Claim Administrator. In order for the Claim Administrator to process claims:

1. Bills must be submitted within 90 days of the date of the covered medical expense.
2. Unless proof of prior payment is submitted, payment for covered medical expenses will be made directly to the provider.
3. Itemized medical bills, if available, should be attached and submitted along with the claim form.

Forward all Medical Claims to:

Cigna
PO Box 188061
Chattanooga, TN 37422-8061

4. When the claim is processed the Covered Person will receive an “Explanation of Benefits”. Such explanation of benefits will explain how the claim was processed, according to the SHBP benefits.

A covered person must submit a benefits claim, and all attachments, within twelve (12) months of the date of service.

For Covered Medical Expenses subject to Precertification, please contact the Claim Administrator at:
For details on the requirements of pre-certification, please see the Preadmission/ Precertification section as listed in the table of contents.

The Plan Sponsor had delegated the administration of claims processing under the SHBP to the Claim Administrator. The Claim Administrator has final authority to determine the amount of benefits that will be paid on any particular item.

In the event a Covered Person has filed a post-service claim for reimbursement of Covered Medical Expenses said person already paid, the Claims Administrator will only inform the Covered Person if the claim is denied in whole or in part. Such notification will be issued within thirty (30) days after the Claim is received by the Claims Administrator. If, due to matters beyond the control of the Claims Administrator, such notification cannot be issued within that thirty (30) day time frame, an extension of up to fifteen (15) days may be granted. If additional information is requested, a Covered Person will have at forty-five (45) days to provide that information to the Claims Administrator.

B. Inquiry, Grievance and Appeals Process

**Adverse Determination** means a determination by Plan Administrator based upon a review of information provided, to deny, reduce, modify, or terminate an admission, continued inpatient stay or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

**Inquiry** means any communication to Plan Administrator by a Covered Person on his behalf that has not been the subject of an adverse determination and that requests redress of an action or omission.

**Internal Inquiry Process** is a process, prior to the Grievance process, during which Plan Administrator will attempt to answer and/or resolve concerns communicated by the Covered Person to his satisfaction. If Plan Administrator fails to answer the Covered Person’s questions or resolve to his satisfaction n within three (3) business days, Covered Person has the option to proceed to the Internal Grievance process.

**Inquiry Procedure:**
(a) If a Covered Person has an Inquiry, he may call the Plan Administrator, Consolidated Health Plans at (877) 657-5044. Plan Administrator will try to resolve Your inquiry within three (3) business days.
(b) If Plan Administrator is unable to resolve the Covered Person’s concerns to his or her satisfaction, Covered Person may, request an internal Grievance.

**First Level Internal Grievance**
If Covered Person receives an Adverse Determination, denial of benefits, has a complaint or is not satisfied with the outcome of an Inquiry, Covered Person or the health care provider acting on
Covered Person’s behalf, may file a Grievance with Plan Administrator within 180 days, requesting a first level review. The request may be by telephone, in person, by mail or by electronic means. Any oral Grievance made by Covered Person will be reduced to writing by Plan Administrator, with a copy will be forwarded to Covered Person within 48 hours or receipt.

Within five (5) working days or receipt of the Grievance, Plan Administrator will provide Covered Person with the name, address and telephone number of the person or organization designated to coordinate the first level review. The reviewers will take into consideration all comments, documents, and other information regarding the request for services submitted. Covered Person is entitled to provide additional written comments, documents, records and other materials relating to the request for benefits for the reviewers to consider when conducting their review. Covered Person is also entitled to receive from Plan Administrator upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the request for benefits as well as any new or additional rationale for denial and a reasonable opportunity to respond to such new evidence or rationale.

We will issue a decision to Covered Person within the time frames provided below:

(a) With respect to a Grievance requesting a first level review of an Adverse Determination involving a prospective review request, Plan Administrator shall notify and issue a decision within a reasonable period of time that is appropriate given the medical condition, but no later than thirty (30) days after the date of receipt of the Grievance requesting the first level review.

(b) With respect to a Grievance requesting a first level review of an Adverse Determination involving a retrospective review request, Plan Administrator shall notify and issue a decision within a reasonable period of time, but no later than sixty (60) days after the date of receipt of the Grievance requesting the first level review.

(c) With respect to a Grievance that does not involve an Adverse Determination, Plan Administrator shall issue a decision within twenty (20) days after the date of receipt of the Grievance requesting a review.

If You appeal, We will review our decision, as well as any additional comments, documentation, records and other information submitted by You, and provide You with a written determination. If We continue to deny the payment, coverage, or service requested or You do not receive a timely decision, You may be able to request an external review of Your claim by an independent third party, who will review the denial and issue a final decision.

Second Level Internal Grievance (Optional)
If a Covered Person is unhappy with the First Level Internal Grievance decision, he has the right to an additional review. Covered Person or his authorized representative may request a Second Level Internal Grievance review within 45 days from receipt of the decision by following the steps outlined above for the First Level Internal Grievance.

The request will be reviewed by a panel, appointed by Plan Administrator, which shall consist of individuals who were not involved in the first level review decision and shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted. Covered Person has the right to appear before this panel at the review meeting which will be held within forty-five (45) working days of the receipt of Your request and will be notified at
least fifteen (15) working days prior to the date of the review meeting. A written decision will be issued within five (5) working days of completing the review.

**Expedited Internal Grievance**

Covered Person or authorized representative may make a request, either orally or in writing, for an expedited internal review of an Adverse Determination involving an admission, availability of care, continued stay or if Covered Person has received Emergency services but have not been discharged from a facility. An expedited review decision will be made and Covered Person will be notified of the decision as soon as possible but in no event more than twenty-four (24) hours after receipt of the request for expedited review.

If the Grievance involves an Adverse Determination with respect to a concurrent review urgent care request, the service(s) in question will be continued until You have been notified of Our determination.

**External Review Process**

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process applies only to:

1. An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

**Standard external review**

Standard external review is external review that is not considered expedited (as described in the “expedited external review” paragraph in this section).

1. **Request for external review.** The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the claimant’s failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
c. The claimant has exhausted the Plan’s internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations;
d. The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization.** The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. **Reversal of Plan’s decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

**Expedited external review**

1. **Request for expedited external review.** The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant’s ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.
3. **Referral to Independent Review Organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process.

4. **Notice of final external review decision.** The Plan’s (or Claim Processor’s) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.