

Idaho State

UNIVERSITY



2011-2012

Student Health Insurance Plan

SHIP

underwritten by
Nationwide Life Insurance Company

policy number
302-110-1109

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INSURANCE ID CARD

A permanent ID card will be mailed to you shortly after the beginning of the Fall Semester. Only one permanent ID card will be mailed to you each school year (not each semester).

If you need to see a doctor prior to receiving your ID card in the mail, you may download a temporary ID Card at www.renstudent.com/isu.

If you don't receive your ID by October 31, or need a replacement card, please contact Renaissance Insurance Agency, Inc. at 1-800-537-1777.

Always carry your insurance ID card with you.

IDAHO STATE UNIVERSITY STUDENT HEALTH CENTER

Welcome to Idaho State University!

We're thrilled you've chosen to study in Pocatello. Your Student Health Center is a resource for all students and their spouses.

This brochure highlights insurance coverage secured through a Consortium of Idaho Colleges and Universities, underwritten by Nationwide Life Insurance Company. It includes benefits designed to coordinate with the services available at your Student Health Center. Please review the information herein to decide if this health insurance plan is a good fit for your needs.

The ISU Student Health Center employs a friendly, professional medical staff to provide you with high-quality, low-cost care while you are attending ISU. We believe that physical health and quality medical care are essential for students during their academic pursuits. The Student Health Center provides a broad spectrum of medical care for short-term illness like colds or treatment of cuts and broken bones as well as for long-term issues like diabetes and high blood pressure. Laboratory and X-ray services are also available, as well as a comprehensive pharmacy.

I encourage you to use the Student Health Center for your medical needs while attending ISU.

Ronald M. Solbrig, M.D.
Director, ISU Student Health Services

Student Health Center Staff

The mission of the Student Health Center (SHC) is to assist students in achieving scholastic goals by providing affordable, quality health care for physical and psychological needs. The staff is there to provide excellent patient care and health education, as well as referrals for outside providers for services not available at the SHC.

The Student Health Center is administered by Dr. Ronald Solbrig. The staff consists of three (3) physicians, three (3) physician assistants, nurses, X-ray technologists, a pharmacist, and clerical staff. A satellite clinic is also available in Idaho Falls.

How To Access the SHC

All fee-paying ISU students, as well as spouses of full-time students, may obtain treatment at the Student Health Center. A valid student or spouse ID card must be shown at each visit to utilize the SHC. Health care for children is not available.

Full-time fee-paying students pay an assessment included in registration fees, which entitles them to access Student Health Center services. Part-time students and spouses of students may also utilize the Student Health Center for a small clinic fee. Students who are not enrolled in classes in Summer, but were enrolled in Spring and are pre-registered for Fall semester may use the Student Health Center during the Summer for a minimal fee. In addition, fees are charged for laboratory, X-ray and miscellaneous services. The SHC staff is able to bill private insurance as well as SHIP.

The SHC provides a full range of medical care, from urgent care to preventative health care, offering same-day morning appointments and advance appointments for special procedures. A walk-in clinic is open at 11:00 a.m. each day.

After-Hours Care and Emergencies

Students are encouraged to wait until the SHC is open for evaluation and treatment for non-emergency conditions. Students will have to pay for any visits outside the SHC at standard rates. When seeking treatment off-campus, students enrolled in the Student Health Insurance Plan (SHIP) are encouraged to use PPO providers.

In the case of an emergency, students should call 911 or seek evaluation and treatment from the nearest urgent care center or hospital emergency room.

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STUDENT HEALTH CENTER (continued from page 1)

NOTE: Emergency care provided at a facility other than the Student Health Center will not be covered at 100%. The student will be responsible for the deductible, and any claim will be paid according to the benefits and limitations of SHIP (or the student's private insurance).

Student Health Center – Main Campus

Location:	990 Cesar Chavez Avenue (across from Graveley Hall)
Mailing Address:	921 South 8th Avenue, Stop 8311, Pocatello, ID 83209
Phone Numbers:	Appointments and Information: 1-208-282-2330 After-hours Physician Exchange: 1-208-525-3708 Fax: 1-208-282-4036
Hours:	Fall and Spring Semester: Monday, Wednesday and Friday..... 8:00 a.m. to 4:30 p.m. Tuesday and Thursday..... 9:00 a.m. to 4:30 p.m. The walk-in clinic opens at 11:00 a.m. each day. Closed on weekends and state holidays. Summer Term: Monday, Wednesday and Friday..... 8:00 a.m. to 3:30 p.m. Tuesday and Thursday..... 9:00 a.m. to 3:30 p.m. Closed on weekends and state holidays.
Website:	www.isu.edu/stuhlth

Student Health Center Pharmacy

Location:	2nd Floor of the Student Health Center
Phone:	1-208-282-3407
Hours:	Monday through Friday..... 12:00 p.m. to 5:00 p.m. (closes at 4:00 p.m. in Summer)

Student Health Center – Idaho Falls Campus

Location:	Bennion Student Union Building, Room 214 1784 Science Center Drive, Idaho Falls, ID 83402
Phone:	Appointments and Information: 1-208-282-7826 Fax: 1-208-282-7850
Hours:	Please call for schedule. Closed on weekends and state holidays.

Unity Health Center – Meridian

Location:	745 South Progress Avenue Meridian, ID 83642
Phone:	1-208-895-6729
Hours:	Monday through Saturday 8:00 a.m. to 8:00 p.m. Sunday 10:00 a.m. to 7:00 p.m.

STUDENT HEALTH CENTER (continued from page 2)

Treatment Available at the SHC

The Student Health Center provides a wide range of medical care. This includes everything from treatment of colds and flu to treatment of high blood pressure and diabetes, as well as care for broken bones, lacerations, abscesses, and other urgent care problems. Preventative health services such as immunizations, nutrition counseling, and birth control are also available.

Standard X-rays and diagnostic ultrasound examinations are provided at a reduced cost compared to off-campus facilities. Registered X-ray technologists staff the X-ray department and all films are read by a radiologist.

The SHC laboratory is staffed by registered professionals who are able to do many simple lab tests on site. More sophisticated blood tests can be obtained through the Student Health Center reference lab.

Services provided for women include health maintenance, disease prevention, Pap smears, contraceptive services, and other women's related health issues or concerns.

In order to meet students' diverse medical needs and also to help keep medical expenses to a minimum, many special medical procedures are available at the Student Health Center. Some special procedures offered are EKGs, spirometry testing, colposcopy, cryosurgery, LEEP, minor surgery of lumps and bumps, IV therapy, event monitoring, light therapy, and acupuncture.

Additional SHC Health Resources

- **Obstetrical:** Prenatal care, abortion, delivery, etc. are not provided at the Student Health Center, but information about referrals is available. Assistance in obtaining appropriate care during pregnancy is offered to the student.
- **Mental Health Counseling:** Mental health counseling is available at ISU Counseling and Testing and at the ISU Psychology Clinic. Referrals can be made by ISU Student Health Center providers.
- **Physical Therapy:** Services are available through the ISU physical therapy clinic and are covered under the Student Health Insurance Plan.
- **Immunizations:** While immunizations are not required of students, all students are urged to obtain needed immunizations or boosters prior to enrollment. Contact the ISU Student Health Center for a list of immunizations that are available.

Pharmacy

Please note that outpatient prescription drugs are NOT covered under SHIP. Students enrolled in SHIP should obtain their prescriptions through the ISU Student Health Center pharmacy whenever possible.

The pharmacy provides low-cost prescription drugs, including some \$4 generic drugs and competitively priced birth control, as well as over-the-counter medication at a reduced cost. Students may wish to transfer prescriptions from their hometown pharmacy to the SHC pharmacy while they are attending school.

A registered pharmacist is on staff at the pharmacy to provide comprehensive service, which includes counseling patients on the proper use of their medication, consulting with patients and providers on appropriate medication choices, and answering medication-related questions (including drug interactions, over-the-counter medications, and medication-related side effects).

To get a price quote on a medication, order a refill, transfer a prescription or for any prescription-related questions, please call **1-208-282-3407**.

Confidentiality

All medical records are confidential and are not released without written authorization or by official court order, except to legally-authorized entities.

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SHIP Insurance Program

For the convenience of students enrolled in SHIP, the insurance premium is automatically included on their bill with registration fees. This program is evaluated by the University Student Health Insurance Advisory Committee and is underwritten by Nationwide Life Insurance Company. Insurance benefits are described in this brochure.

Student Health Center Benefits Under SHIP

The following benefits will be paid at 100% of Covered Charges at the ISU Student Health Center and Unity Health Center in Meridian:

- X-rays and laboratory
- Emergency care
- Splints, crutches, immobilizers, casts, bandages, sutures
- Supplies needed for minor surgery and procedures, procedure trays, dressings and use of specialized equipment
- Medicines and injections administered during treatment
- Fertility tests
- Pap smear
- STD screening
- One lipid profile per year
- One physical exam per year (this does not include routine or preventative immunizations or medicines)
- Diabetic supplies including blood glucose test strips, lancets, insulin syringes, sharps containers and alcohol swabs
- Physical therapy and occupational therapy received at the ISU physical therapy clinic

The Deductible and Pre-Existing Condition Limitation will be waived when treatment is received at the ISU Student Health Center or Unity Health Center in Meridian. In addition, the Deductible will be waived for outpatient treatment of Mental Disorders when received by the Pocatello Family Medicine Clinic upon referral from the ISU Student Health Center.

STUDENT HEALTH INSURANCE PLAN (SHIP) ELIGIBILITY

Students

The following students are automatically covered under the Student Health Insurance Plan (SHIP), unless proof of other comparable coverage is provided and a waiver is submitted by the Waiver Deadline Date each semester or session:

- All full-time fee paying domestic undergraduate students enrolled in at least 12 credit hours
- All full-time fee paying domestic graduate students enrolled in at least nine (9) credit hours
- All international students enrolled in at least one (1) credit hour
- All full-time session fee paying 8-Week session students enrolled in at least six (6) credit hours per session

Part-time students (except international students) are not eligible for SHIP.

Covered Students must actively attend classes for at least the first 31 days of the period for which coverage is purchased. Except in the case of medical withdrawal, as verified and approved by the school, any student withdrawing from school during the first 31 days of the period for which coverage is purchased will not be covered under this Policy and a full refund of premium will be made (provided no claims have been filed). Students withdrawing after such 31-day period will remain covered under the Policy for the term purchased and no refund will be allowed. Home study, correspondence, internet and television (TV) courses do not fulfill the eligibility requirements that the student actively attend classes (except those required for fulfillment of a degree program).

Nationwide Life Insurance Company (hereinafter "the Company") maintains its right to investigate student (and Dependent) status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium less any claims paid.

Graduating Students

Students who are graduating are eligible to enroll in SHIP Continuation for three (3) additional months after the termination date of their final term of coverage in SHIP. Students must enroll for SHIP Continuation coverage within 31 days of the termination date of that term. The three (3) month SHIP Continuation coverage may only be purchased once per lifetime.

Dependents

Covered Students may also insure their eligible Dependents.

If a child is born to a Covered Student, that child will be covered under the plan for the first 60 days after: 1) the birth date of the newly born child; 2) the effective date of adoption of the child by the student; or 3) the date of placement of the child for adoption with the student. Coverage for such child will be for Sickness and Injury, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care. Should the student's coverage terminate before the end of the 60-day period, newborn coverage will not extend beyond the student's termination date.

The Covered Student will have the right to continue coverage for the child beyond 60 days. To continue the coverage, the Covered Student must: 1) notify Renaissance Insurance Agency, Inc. by the 60th day; and 2) pay the full cost of coverage for the applicable term, if required. Once Renaissance has been notified, the Covered Student will have 31 days (in addition to the initial 60 days) to submit payment of any additional premium. If the Covered Student does not use this right as stated here, all coverage as to that child will terminate at the end of the 60-day period.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under the policy.

WAIVER PROCEDURE

Students who wish to waive coverage under the plan must submit satisfactory proof of comparable and verifiable continuing health insurance coverage by the Waiver Deadline Date **each semester or session**. In order to qualify for a waiver, the student must be continuously covered under a health insurance plan for the entire school term, which includes, at a minimum, the following:

- Maximum Benefit of at least \$100,000 per policy year;
- Deductible of \$5,000 or less per person, whether an individual or family deductible (though a maximum \$1,000 deductible is strongly recommended);
- For international students, the plan must have at least \$10,000 of repatriation coverage and \$15,000 of medical evacuation coverage; and
- Company must be owned, operated and based in the United States and must be in full compliance with applicable federal laws. International students may not waive with insurance from their home country.

Students who are covered under a plan that does not meet all of these requirements will not be allowed to waive coverage under this plan and the premium will be added to their school bill.

Students who are eligible to waive coverage under this plan must go to www.renstudent.com/isu to submit a waiver request. The waiver must be completed by the Waiver Deadline Date each semester or session. Please see the Waiver FAQ for more details, which is available at www.renstudent.com/isu.

Deadline to Waive Coverage in SHIP

Fall: September 2, 2011

Spring/Summer: January 23, 2012

Summer: May 29, 2012

Please note the waiver deadline for 8-Week Session students will be 10 business days from the start date of the applicable session (see Terms of Coverage).

ENROLLMENT PROCEDURE

Students

All eligible students who have not waived coverage by the Waiver Deadline Date each semester will be automatically enrolled in the plan. The cost for SHIP is included in the tuition fee bill each semester.

If an eligible student has waived out of the plan and later experiences an Involuntary Loss of Coverage, he or she may enroll in SHIP for the remainder of the current term by submitting proof of loss of coverage and proper payment *within 31 days of termination of prior coverage*. To enroll in SHIP after an Involuntary Loss of Coverage, contact the Student Insurance Office on campus. Please note premium payments cannot be prorated. Students must pay the entire premium for the term in which they are electing to enroll.

Dependents

Students may enroll eligible Dependents in the plan online with a MasterCard or Visa at www.renstudent.com/isu by the Dependent Enrollment Deadline Date. Students who wish to pay by check or money order may download a Dependent enrollment form from www.renstudent.com/isu and submit the completed form, along with the proper payment, to Renaissance Insurance Agency, Inc. (must be postmarked by the Dependent Enrollment Deadline Date).

If a student wishes to enroll a new Dependent, and it is past the Dependent Enrollment Deadline Date, the student must contact Renaissance Insurance Agency, Inc. at 1-800-537-1777. Newly acquired Dependents (spouse and/or children) are not subject

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ENROLLMENT (continued from page 6)

to the Dependent Enrollment Deadline Dates. However, enrollment and payment (if required) for all newly acquired Dependents must be received within 60 days of marriage or within 91 days of birth or placement of a Dependent child as defined herein. **Otherwise, enrollment and payment cannot be accepted after the Dependent Enrollment Deadline Dates listed.**

SHIP Continuation

Students may enroll in SHIP Continuation online with a MasterCard or Visa at www.renstudent.com/isu within 31 days of the termination date of their current coverage under SHIP. Students who wish to pay by check or money order may download an enrollment form from www.renstudent.com/isu and submit the completed form, along with the proper payment, to Renaissance Insurance Agency, Inc. (must be postmarked within 31 days of the termination date of current coverage under SHIP). Eligible Dependents of enrolled students may also be enrolled under SHIP Continuation provided they were also covered under SHIP in the immediately preceding term. The three (3) month SHIP Continuation coverage may only be purchased once per lifetime.

For questions about enrollment, please contact Renaissance Insurance Agency, Inc. at 1-800-537-1777.

COSTS OF COVERAGE

	Fall	Spring/Summer	Summer
Student	\$ 534.00	\$ 736.00	\$ 318.00
Spouse	\$ 698.00	\$ 965.00	\$ 416.00
Child(ren)	\$ 599.00	\$ 828.00	\$ 357.00
8-Week Sessions*	Session I-IV	Session V	
Student	\$ 238.00	\$ 318.00	
Spouse	\$ 311.75	\$ 416.00	
Child(ren)	\$ 267.50	\$ 357.00	

*Cost is per session

Continuation Coverage	3 Months
Student	\$ 656.00
Spouse	\$ 857.00
Child(ren)	\$ 736.00

The Spouse and Child(ren) costs are in addition to the Student cost.

The costs of coverage include insurance premium and administrative fees.

PREMIUM REFUNDS

Except in the case of a medical withdrawal, if a student withdraws from school during the first 31 days of coverage under the plan, a full refund of premium for the applicable term will be made upon request and the coverage will be as if it had never been in effect. In addition, if a student enters full-time active military service or, in the case of an international student, permanently returns to his or her home country or country of regular domicile, a pro rata refund will be issued only upon written request from the school. Otherwise, premium refunds are not allowed. **In the event a claim has been paid, premium is fully earned and a refund is not available under any circumstances.**

TERMS OF COVERAGE

Effective Date

Coverage for students enrolled in SHIP will become effective at 12:01 a.m. on the effective date of the term for which premium has been paid. Coverage for students who are new intercollegiate athletes will become effective at 12:01 a.m. on 08/01/11.

For students who previously waived coverage under SHIP and elect to enroll later due to an Involuntary Loss of Coverage, coverage will be effective at 12:01 a.m. on the day **after** the date that enrollment and payment are received by the Student Insurance Office, provided it is within 31 days of the termination of prior coverage.

Coverage for eligible Dependents becomes effective at 12:01 a.m. on the latest of: 1) the first date of the applicable term in which the Dependent is enrolling; 2) the day **after** the date that online enrollment is completed; or 3) the day **after** the date that full payment and completed application received by mail are postmarked.

Coverage for students (and Dependents, if applicable) enrolling in SHIP Continuation becomes effective at 12:01 a.m. on the termination date of their final term of coverage as a registered student, provided enrollment and payment are received within 31 days of this date.

Termination Date

Coverage terminates at 12:01 a.m. on the earliest of the following dates:

1. The date the Policy is terminated by the Policyholder or the Company;
2. The last day of the Term of Coverage for which premium is paid;
3. The date an Insured Person enters full-time active military service or, for international students, the date the Insured Person permanently returns to his or her home country;
4. The last day of the period through which premium has been paid, following the date a Dependent ceases to be a Dependent as described herein.

Dependent coverage will not be effective prior to that of the student or extend beyond that of the student, except as specifically provided under the Extension of Benefits provision.

Term	Effective Date	Termination Date	Waiver Deadline	Dependent Enrollment Deadline
<i>Students and Dependents</i>				
Fall	08/15/11	01/01/12	09/02/11	09/15/11
Spring/Summer	01/01/12	08/15/12	01/23/12	02/01/12
Summer	05/15/12	08/15/12	05/29/12	06/15/12
<i>8-Week Session Students and Dependents</i>				
Session I	08/15/11	10/17/11	09/02/11	09/15/11
Session II	10/17/11	01/01/12	10/28/11	11/17/11
Session III	01/01/12	03/06/12	01/23/12	02/01/12
Session IV	03/06/12	05/15/12	03/17/12	04/06/12
Session V	05/15/12	08/15/12	05/29/12	06/15/12

We do not send termination or renewal notices. It is the Insured Person's responsibility to renew coverage in a timely manner, subject to continuing eligibility. Eligibility requirements must be met each time premium is paid to continue coverage.

EXTENSION OF BENEFITS

The coverage provided under this Policy ceases on the Insured Person's termination date. However, if an Insured Person is totally disabled on the termination date from a covered Injury or Sickness for which benefits were paid, Covered Charges for such Injury or Sickness will continue to be paid until the date the disability ends, or for a period of 12 months, whichever is earlier.

The total payments made in respect of the Insured Person for such condition both before and after the termination date will never exceed the Policy Year Maximum Benefit. After this Extension of Benefits provision has been exhausted, all benefits cease to exist and under no circumstances will further benefits be made. This provision is applicable only to the extent the Insured Person is not enrolled in the ensuing term of coverage in this plan or other similar health insurance coverage.

Dependents that are newly acquired during the Covered Student's Extension of Benefits period are not eligible for benefits under the provision.

Totally disabled means, with respect to the Covered Student, the inability to attend classes at the location where he or she is enrolled. With respect to a Dependent, or the Covered Student if such classes are not in session, totally disabled means the inability to perform those activities that are normal for a person in good health of the same age and sex.

PREFERRED PROVIDER ORGANIZATION

This plan has incorporated into the coverage access to a Preferred Provider Organization (PPO) of Doctors, Hospitals and other facilities who have contracted to provide specific medical care at a discounted, negotiated rate. The Preferred Provider Organizations for this plan are the Idaho Physicians Network (IPN), which is available for local and statewide medical care, and First Health Network (FHN) which is available for medical care nationwide when seeking treatment outside of Idaho.

In-Network Providers (PPO)

Network access provides benefits nationwide for Covered Charges incurred at 80% of the Preferred Allowance for a covered Injury or Sickness when treated by network providers. When utilizing a PPO provider or facility there will be a 20% out-of-pocket Coinsurance expense for which the Insured Person is responsible.



When the out-of-pocket Coinsurance amount an Insured Person pays for Covered Charges incurred for treatment by a PPO Provider exceeds \$4,000 for all conditions during a Policy Year, the Policy will pay 100% of additional Covered Charges incurred for treatment by a PPO Provider for the remainder of the Policy Year, up to the Policy Year Maximum Benefit.

For a complete listing of the PPO Hospital and Doctor facilities **within Idaho**, call the Idaho Physicians Network (IPN) at **1-866-476-1076** or visit **www.ipnmd.com**.

For PPO Hospital and Doctor facilities **outside of Idaho**, call the First Health Network at **1-800-226-5116** or visit **www.myfirsthealth.com**.

If an Insured Person is being treated by a Preferred Provider for an acute, serious chronic condition, pregnancy, newborn, or a terminal illness, and the Provider's contract terminates with the PPO, the Insured Person may be eligible under certain conditions to continue treatment with the Provider at the PPO rate. Contact the claims administrator for details.

Please be aware that if an Insured Person is treated at a PPO Hospital, it does not mean that all providers at that Hospital are PPO providers. In addition, if an Insured Person is referred by a PPO provider to another provider or facility, it does not mean that the provider or facility to which the Insured Person is referred is also a PPO provider. For instance, if a network Doctor gives a referral to a non-network lab for tests or a non-network anesthesiologist is used for a surgery in a network Hospital, the Insured Person will have to pay the higher Coinsurance for the non-network providers. It is the Insured Person's responsibility to verify that a provider is currently a member of the PPO Network. This information can be found on the network websites listed above.

Out-of-Network Providers (non-PPO)

If a non-PPO provider or facility is utilized, coverage is available worldwide at 60% of Reasonable and Customary Expenses (R&C). If a non-PPO provider or facility is utilized, there is a 40% Coinsurance factor for which the Insured Person is responsible. Covered Charges for Emergency treatment by a non-PPO provider or facility will be paid at 80% of R&C.

When the out-of-pocket Coinsurance amount an Insured Person pays for Covered Charges incurred for treatment by a non-PPO Provider exceeds \$6,000 for all conditions during a Policy Year, the Policy will pay 100% of additional Covered Charges incurred for treatment by a non-PPO Provider for the remainder of the Policy Year, up to the Policy Year Maximum Benefit.

SCHEDULE OF BENEFITS

The Company will pay for the Covered Charges listed below, up to the following limits.

Please note that in the Schedule of Benefits, the term "SHC" refers to either the ISU Student Health Center or Unity Health Center in Meridian, except as specified.

DEDUCTIBLE

The Insured Person is responsible for paying the Deductible amount listed before the Company will begin paying benefits.

In-Network Providers: \$250 per Policy Year

Out-of-Network Providers: \$500 per Policy Year

The Deductible is waived at the ISU Student Health Center (including the Physical Therapy Clinic) and Unity Health Center in Meridian.

COINSURANCE MAXIMUM LIMIT

Once the Deductible has been met, the Policy pays 80% of Covered Charges when utilizing in-network providers and 60% of Covered Charges when utilizing out-of-network providers, except as specified below. If the out-of-pocket Coinsurance amount an Insured Person pays for Covered Charges exceeds the Coinsurance Maximum Limit for all conditions during a Policy Year, the Policy will pay 100% of additional Covered Charges for the remainder of the Policy Year, up to the Policy Year Maximum Benefit.

In-Network Providers: \$4,000 per Policy Year

Out-of-Network Providers: \$6,000 per Policy Year

POLICY YEAR MAXIMUM BENEFIT

After satisfaction of the Deductible, the Company will pay for Medically Necessary Covered Charges incurred as the result of a Sickness or Injury, according to the applicable limits stated below, up to the Policy Year Maximum Benefit of \$250,000 for all conditions combined.

COVERED CHARGES are limited to the following:

INPATIENT	
HOSPITAL CONFINEMENT ROOM AND BOARD daily average semi-private room rate and general nursing care provided by a Hospital	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
INTENSIVE CARE	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
HOSPITAL CONFINEMENT MISCELLANEOUS such as the cost of the operating room, laboratory tests, X-ray examinations including professional fees, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services and supplies; dressings; oxygen tent	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
MATERNITY AND NEWBORN CARE during Hospital Confinement, including routine nursery care provided immediately after birth	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: paid as any other Sickness, up to 48 hours after birth (96 hours for cesarean delivery)

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INPATIENT (continued)	
SURGICAL EXPENSE	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: if multiple procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures
ASSISTANT SURGEON	PPO: 20% of Surgical Expense NON-PPO: 20% of Surgical Expense
ANESTHETIST professional services in connection with inpatient surgery	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
REGISTERED NURSE EXPENSE private duty nursing care while Hospital Confined, including a licensed practical nurse (LPN)	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
PRE-ADMISSION TESTING if testing occurs within 7 working days prior to admission	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
PHYSICAL THERAPY	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
DOCTOR VISITS	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: limited to one visit per day
TREATMENT OF MENTAL DISORDERS AND/OR ALCOHOL AND SUBSTANCE ABUSE for inpatient or intermediate care	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: limited to one visit per day; up to a maximum of \$7,000 per Policy Year
OUTPATIENT	
DOCTOR VISITS does not apply when related to physical therapy	SHC: 100% of Covered Charges PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: limited to one visit per day
EMERGENCY EXPENSE for use of Hospital emergency room, operating room, laboratory and X-ray examinations, and supplies	SHC: 100% of Covered Charges PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C (80% in the case of an Emergency) COPAY: \$200 per visit (waived at SHC or if admitted to Hospital)
URGENT CARE CENTER	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C

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OUTPATIENT (continued)	
DAY SURGERY MISCELLANEOUS scheduled surgery performed in a Hospital or outpatient facility, including use of operating room, laboratory tests and X-ray examinations including professional fees, anesthesia, drugs or medicines (excluding take-home) and supplies	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
SURGICAL EXPENSE	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: If multiple procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures
ASSISTANT SURGEON	PPO: 20% of Surgical Expense NON-PPO: 20% of Surgical Expense
ANESTHETIST professional services in connection with outpatient surgery	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
ANNUAL PHYSICAL EXAM does not include routine or preventive immunizations or medicines	SHC: 100% of Covered Charges PPO: not covered NON-PPO: not covered LIMIT: limited to one exam per policy year
LABORATORY TESTS	SHC: 100% of Covered Charges PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
DIAGNOSTIC SERVICES includes X-rays, CAT scans, PET scans, MRI and nuclear medicine	SHC: 100% of Covered Charges PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
TESTS AND PROCEDURES includes diagnostic services and medical procedures performed by a Doctor (that aren't covered under Doctor Visits, Physical Therapy, Laboratory Tests or Diagnostic Services)	SHC: 100% of Covered Charges PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
INJECTIONS when administered in a Doctor's office and charged on the Doctor's statement	SHC: 100% of Covered Charges PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
TREATMENT OF MENTAL DISORDERS AND/OR ALCOHOL AND SUBSTANCE ABUSE the Deductible is waived for treatment received at the Pocatello Family Medicine Clinic when referred by the SHC	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: limited to one visit per day; up to a maximum of 12 visits per Policy Year

(continued on page 14)

OUTPATIENT (continued)	
PHYSICAL THERAPY includes chiropractic treatment and occupational therapy	SHC: 100% of Covered Charges at SHC Physical Therapy Clinic PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: limited to one visit per day; up to a maximum of \$50 per visit and \$750 per Policy Year (except at SHC)
RADIATION THERAPY AND CHEMOTHERAPY	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
OTHER	
AMBULANCE SERVICES for ground and air	PPO: 80% of R&C NON-PPO: 80% of R&C LIMIT: for Emergency only
CONSULTANT SERVICES when requested and approved by the attending Doctor	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C
DURABLE MEDICAL EQUIPMENT OR BRACES AND APPLIANCES a written prescription must accompany the claim when submitted <i>Includes equipment and supplies for the management and treatment of diabetes</i>	SHC: 100% of Covered Charges PPO: 80% of Preferred Allowance NON-PPO: 80% of R&C LIMIT: replacement braces and appliances are not covered
DENTAL TREATMENT for Injury to sound, natural teeth or extraction of abscessed teeth or impacted wisdom teeth only	PPO: 80% of R&C NON-PPO: 80% of R&C
PREGNANCY including complications of pregnancy	PPO: 80% of Preferred Allowance NON-PPO: 60% of R&C LIMIT: paid as any other Sickness

BREAST CANCER SCREENING

Coverage is provided for mammography examinations at the following intervals: 1) one baseline mammogram for any woman who is 35 through 39 years of age; 2) a mammogram every two years for any woman who is 40 through 49 years of age, or more frequently if recommended by the woman's Doctor; 3) a mammogram every year for any woman who is 50 years of age or older; and 4) a mammogram for any woman desiring a mammogram for medical cause.

BREAST RECONSTRUCTION FOLLOWING MASTECTOMY

Coverage is provided for breast reconstruction following mastectomy, including reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses (e.g. breast implant) and treatment for physical complications of the mastectomy, including lymphedema.

GENERAL EXCLUSIONS

No benefits will be paid for loss or expense caused by, contributed to, or resulting from, or treatment, services, or supplies for, at, or related to:

1. Eyeglasses, contact lenses including but not limited to routine eye refractions, eye exams, radial keratotomy or similar surgical procedures to correct vision, except in the case of Injury;
2. Hearing screenings or hearing examinations or hearing aids and the fitting or repairing of hearing aids, except in the case of Injury;
3. Vaccinations, inoculations and preventive shots: a) required for travel; b) required for employment; c) provided as wellness or prevention; except as specifically provided herein;
4. Care of corns, calluses, or bunions;
5. Cosmetic surgery, plastic surgery, resulting complications, consequences and after effects or other services and supplies that the Company determines to be furnished primarily to improve appearance rather than a physical function or control of organic disease, except as provided herein or for treatment of an Injury that is covered under the Policy. Improvements of physical function do not include improvement of self-esteem, personal concept of body image, or relief of social, emotional, or psychological distress. Procedures not covered include, but are not limited to: face lifts, rhinoplasty, sagging eyelids, prominent ears, skin scars, baldness, and correction of breast size, asymmetry or shape by means of reduction, augmentation, or breast implants (except for correction of deformity resulting from mastectomy or lymph node dissection). This exclusion does not include reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child;
6. Sexual reassignment surgery;
7. Treatment, service, or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved;
8. Treatments which are considered to be unsafe, Experimental, or Investigational by the American Medical Association (AMA) and resulting complications;
9. Treatment on or to the teeth or gums, except as provided herein;
10. TMJ;
11. Injury sustained while: a) participating in any intercollegiate or professional sport, contest, or competition; b) traveling to or from such sport, contest, or competition as a participant; or c) while participating in any practice or conditioning program for such sport, contest, or competition;
12. Injury resulting from parachuting, hang gliding, skydiving, parasailing, bungee jumping, glider flying or sail planing;
13. Injury occurring in consequence of riding or otherwise being in any vehicle or device of aerial navigation, except as a fare-paying passenger on a regularly scheduled flight of a commercial airline;
14. Reproductive/infertility services including but not limited to: fertility tests, infertility (male or female) including any services or supplies rendered for the purpose or with the intent of inducing conception, except as provided at the SHC. Examples of fertilization procedures are ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance reproductive ability; artificial insemination; premarital examination; impotence, organic or otherwise;
15. Sterilization or sterilization reversal; vasectomy; prescription and non-prescription birth control, except as specifically provided herein;
16. Routine newborn infant care, well baby nursery and related Doctor charges including circumcision and congenital conditions, except as specifically provided for in this Policy for newborn or adopted infants;

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GENERAL EXCLUSIONS (continued from page 15)

17. Elective termination of pregnancy including the morning after pill, except to preserve the life of the female upon whom the abortion is performed;
18. Hospital Confinement or any other services or treatment for which the Insured Person is not legally obligated to pay or for which no charge is made;
19. Services provided normally without charge by the health service of the University, or services covered or provided by a student health fee;
20. Treatment in a government Hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
21. Any services of a Doctor, nurse, or health care practitioner who lives with the Insured Person or who is related to the Insured Person by blood or marriage;
22. Services received after the Insured Person's coverage ends, except as specifically provided under the Extension of Benefits Provision;
23. Testing and treatment of learning disabilities;
24. Injury caused by, contributed to or resulting from the Insured Person's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage or for the purposes as prescribed by the Insured Person's Doctor;
25. Services for the treatment of any Injury or Sickness incurred while committing a felony or while taking part in an insurrection or riot;
26. Any and all over the counter smoking cessation and treatment of nicotine addiction products;
27. Services and associated expenses for the treatment of obesity and any resulting complications, consequences and after effects of treatment that involves surgery and any other associated expenses, including, but not limited to: a) gastric or intestinal bypasses; b) gastric balloons; c) stomach stapling; d) wiring of the jaw; e) pan-niculectomy; f) appetite suppressants; g) surgery for removal of excess skin or fat;
28. Injury or Sickness for which benefits are paid or payable under any workers' compensation or occupation disease law or act, or similar legislation;
29. War or any act of war, declared or undeclared; or while in the armed forces of any country;
30. Solid organs, including but not limited to: autologous and allogenic bone marrow transplants, autologous and allogenic stem cell transplants, including non-human organs or bone marrow; anything caused by, contributed to, or resulting from an organ transplant, including complications thereof;
31. Acupuncture or acupressure; aroma therapy; hypnotism; rolfing; biofeedback;
32. Voluntary, elective or prophylactic treatment (medical, surgical or pharmacological) for a condition that is not presently exhibiting symptoms, or is in absence of a disease state or condition that is presently creating pathological changes to any body structure or function;
33. Nasal and sinus surgery, except surgery made necessary as the result of a covered Injury or acute purulent sinusitis;
34. Preventive testing or treatment or screening exams or testing in the absence of Injury or Sickness, except as provided herein;
35. Lipectomy services and supplies related to surgical or suction-assisted lipectomy;
36. Patient controlled analgesia (PCA);
37. Services, supplies or treatment for: allergy testing or treatment; acne (including Accutane); alopecia and hirsutism;
38. Weight management services and supplies;
39. Expenses incurred for any experimental drug or drug combination that the Federal Food and Drug Administration (FDA) has not approved for any indication, or for any drug that the FDA has determined to be contraindicated for a particular condition;
40. Outpatient prescription drugs; and
41. Congenital birth anomalies, except as mandated for newborn children.

PRE-EXISTING CONDITION LIMITATION

The Pre-Existing Condition Limitation is waived for treatment received at the ISU Student Health Center or Unity Health Center in Meridian.

Otherwise, Pre-Existing Conditions are not covered for the first 12 months following the Insured Person's Effective Date of coverage under the Policy.

This limitation will not apply if, during the period immediately preceding the Insured Person's Effective Date of coverage under this Policy, the Insured Person was covered under prior Creditable Coverage for 12 consecutive months. Prior Creditable Coverage of less than 12 months will be credited toward satisfying the Pre-Existing Condition limitation. This waiver will apply only if the Insured Person becomes eligible and applies for coverage within 63 days of termination of his or her prior coverage.

Pregnancy, including complications of pregnancy, shall not be considered a Pre-Existing Condition under the Policy. In addition, this limitation will not apply to a newborn Dependent child or a child adopted by the Covered Student or placed with the Covered Student for adoption, if the adoption or placement for adoption occurs while the Covered Student is covered under the Policy.

Creditable Coverage includes:

- Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-Insured employer plan, or any other entity, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.
- The Federal Medicare programs pursuant to Title XVIII of the Social Security Act.
- The Medicaid program pursuant to Title XIX of the Social Security Act.
- Any other publicly sponsored program, provided in this state or elsewhere, of medical, Hospital and surgical care.
- 10 U.S.C.A. Chapter 55 (commencing with Section 1071) (Civilian Health and Medical Program of the Uniformed services (CHAMPUS)).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- A health plan offered under 5 U.S.C.A. Chapter 89 (commencing with Section 8901) (Federal Employees Health Benefits Program (FEHBP)).
- A public health plan as defined in federal regulations authorized by Section 2701(c) (1)(I) of the Public Health Service Act, as amended by Public Law 104-191, the Health Insurance Portability and Accountability Act of 1996.
- A health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C.A. Sec. 2504(e)).
- Any other Creditable Coverage as defined by subsection (c) of Section 2701 of Title XXVII of the federal Public Health Services Act (42 U.S.C. Sec. 300gg(c)).

COORDINATION OF BENEFITS

If an Insured Person is covered under one or more other plans, the benefits payable under this Policy will be coordinated with the benefits payable under the other plan(s). Coordination of Benefits means the order in which claims are paid. Coordination permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed 100% of the total allowable expenses. For further explanation of Coordination of Benefits, please see the policy on file at the University or contact the claims administrator.

DEFINITIONS

The terms shown below shall have the meaning given in this section whenever they appear in the brochure.

Accident means an event that is sudden, unexpected, and unintended, and over which the Insured Person has no control.

Coinsurance means the percentage of the expense for which the Insured Person is responsible for a covered service.

Coinsurance Maximum Limit means the maximum amount of money an Insured Person pays for Coinsurance amounts in a Policy Year. This amount is shown in the Schedule of Benefits. There are separate Coinsurance Maximum Limit amounts for in-network and out-of-network benefit levels.

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

Covered Charge means those charges for any treatment, services or supplies: 1) for network providers not in excess of the Preferred Allowance; 2) for non-network providers not in excess of the Reasonable and Customary Expense therefore; and 3) not in excess of the charges that would have been made in the absence of this insurance; and 4) incurred while this Policy is in force as to the Insured Person, except with respect to any covered expense payable under the Extension of Benefits Provision.

Covered Student means an eligible student of the University who is insured under the Policy.

Deductible means the amount of expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

Dependent means a person who is the Covered Student's:

1. Legally married spouse, who is not legally separated from the Covered Student and resides with the Covered Student; or
2. Unmarried child under the age of 25 who receives more than one-half of his or her financial support from the Covered Student. The term child refers to the Covered Student's unmarried:
 - a) Natural child;
 - b) Stepchild or foster child. A stepchild is a Dependent on the date the Covered Student marries the child's parent. A foster child is a Dependent from the moment of placement with the Covered Student as certified by the agency making the placement; or
 - c) Adopted child, including a child placed for adoption with the Covered Student, from the moment of placement as certified by the agency making the placement. Placed for adoption or placement means the assumption and retention by a Covered Student of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a Covered Student terminates upon the termination of that legal obligation.

Doctor means: 1) a legally qualified physician licensed by the state in which he or she practices; 2) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner;

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DEFINITIONS (continued from page 18)

or 3) a certified nurse midwife while acting within the scope of that certification. The term does not include a person who ordinarily resides in the Insured Person's home or is related to the Insured Person by blood or marriage.

Emergency means Sickness or Injury for which immediate medical treatment is sought at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; or
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Experimental/Investigational means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication.

Hospital means a facility which provides diagnosis, treatment, and care of persons who need acute inpatient hospital care under the supervision of Doctors. It must be licensed as a general acute care hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the treatment of mental or psychoneurotic disorders. Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition.

Hospital does not include an institution, or part thereof, which is other than incidentally a nursing home, a convalescent hospital, or a place for rest or the aged.

Hospital Confinement means confinement in a Hospital for at least 18 hours for which a room and board charge is made by reason of Sickness or Injury for which benefits are payable. The readmission for the same or related Sickness or Injury, within a 72 hour period, will be considered a continuation of confinement.

Injury means bodily Injury due to a sudden, unforeseeable, external event which results solely, directly and independently of disease, bodily infirmity or any other causes. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Insured Person means an eligible student or eligible Dependent who has been accepted for coverage and who has paid the required premium.

Involuntary Loss of Coverage means that prior coverage has been involuntarily terminated due to no fault of the Insured Person, which includes coverage that terminates due to a loss of employment by the student or the student's spouse or parent. This definition does not include coverage that has a predetermined termination date, or expiration of COBRA eligibility, and does not apply to coverage that has been voluntarily terminated.

Medically Necessary means a treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided.

A treatment, drug, device, procedure, supply or service shall not be considered Medically Necessary if it:

1. Is Experimental/Investigational or for research purposes;
2. Is provided solely for educational purposes or the convenience of the patient, the patient's family, Doctor, Hospital or any other provider;
3. Exceeds in scope, duration or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;

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DEFINITIONS (continued from page 19)

4. Could have been omitted without adversely affecting the patient's condition or the quality of medical care;
5. Involves treatment with or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA). If the prescribed drug is recognized as safe and effective for the treatment of a Sickness or Injury by one or more of the Standard Medical Reference Compendia or in the Medical Literature, even if the prescribed drug has not been approved by the FDA for the treatment of that specific Sickness or Injury, coverage will be provided, subject to the exclusions and limitations of the Policy;
6. Involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
7. Can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

Mental Disorder means nervous, emotional, and mental disease, illness, syndrome or dysfunction classified in the most recent addition of the Diagnostic and Statistical Manual of Mental Disorders (DSM IV) or its successor as a mental disorder on the date medical care or treatment is rendered to an Insured Person.

Policy Year Maximum Benefit means the maximum payment the Company will make under the Policy for each Insured Person for Covered Charges.

Pre-Existing Condition means Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the six (6) consecutive months prior to the Insured Person's Effective Date of coverage under the Policy.

Preferred Allowance means the amount a network provider has agreed to accept as payment in full for Covered Charges.

Reasonable and Customary Expense (R&C) means the most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:

1. The actual amount charged by the provider;
2. The negotiated rate, if any; or
3. The charge which would have been made by a provider of medical services for a comparable service or supply in the same geographic area, as reasonably determined by the Company.

Geographic area means the first three digits of the zip code in which the service, treatment, procedure, drugs or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable charges, fees or expenses as used herein to describe expense, will be considered to mean the percentile of the payment system in effect on the Effective Date of the Policy.

Sickness means illness, disease, pregnancy and complications of pregnancy. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same sickness.

CLAIM PROCEDURE

In the event of an Injury or Sickness, the SHC and most network (PPO) providers will submit the claim directly to AmeriBen for you. However, if the provider does not file the claim for you, you will be responsible for submitting the claim for reimbursement. In this case, follow these instructions:

1. After you receive treatment, complete the insurance company claim form.
 - a) You may download a claim form from www.myameriben.com.
 - b) Answer all the questions and be sure to sign the claim form before submitting it.
2. If you have any other expenses such as medicines, X-rays or laboratory charges, be sure to attach these bills to the claim form.
3. Send your claim form and all other bills or receipts to AmeriBen at the address below. Try to have all itemized bills attached to the same claim form.
 - a) Please do not send bills without completed claim form. Bills cannot be considered unless all the information required on the claim form is submitted.
 - b) A properly completed claim form must be submitted for each Injury or Sickness.
4. Claim forms and bills should be sent to:

AmeriBen
P.O. Box 6947
Boise, ID 83707-0947

Providers may submit claims electronically:
PAYER ID 75137

5. If you have questions about the status of your claim after it has been submitted, please call AmeriBen at **1-877-955-1559** (Monday–Friday, 7:00 a.m. to 6:00 p.m.). You may also log on to www.myameriben.com to check on your claim status, view your Explanation of Benefits (EOB), access answers to frequently asked questions or submit inquiries by email directly to the AmeriBen Customer Care Center.

A claim must be submitted within 90 days after an Injury or Sickness has occurred, or as soon thereafter as is reasonably possible, in order for the claim to be paid.

You have the right to request an independent medical review if health care services have been improperly denied, modified, or delayed based on medical necessity.

Always keep a copy of all documents submitted for claims.

TRAVEL ASSISTANCE PROGRAM

The following is a detailed description of covered services included under the Travel Assistance Program provided to students and Dependents who are enrolled in the Student Health Insurance Plan (SHIP). The Travel Assistance Program is provided through Nationwide Life Insurance Company, in association with OnCall International. All services must be provided by the Travel Assistance Program. Any expenses associated with these services are the insured student's responsibility except as provided herein. No claims for reimbursement will be accepted.

Coverage begins only when a covered participant is 100 miles or more from his or her primary residence or when in a foreign country, except as specified herein.

WORLDWIDE 24-HOUR EMERGENCY TRAVEL ASSISTANCE

If you are traveling and have an emergency, please contact the call center, OnCall International, available 24 hours a day, seven days a week:

Call from the United States or Canada: 1-866-525-1957

Call collect from anywhere else in the world: 1-603-898-9159

Email: mail@oncallinternational.com

EMERGENCY TRANSPORTATION SERVICES

Emergency Evacuation: If you suffer an Injury or Sickness and adequate medical facilities are not available locally in the opinion of the Travel Assistance Program's Medical Director, the Travel Assistance Program will provide emergency evacuation (under medical supervision, if necessary) by whatever means necessary to the nearest facility capable of providing adequate care. Services include arranging and paying for transportation and related medical services (including cost of medical escort, if necessary) and medical supplies necessarily incurred in connection with the emergency evacuation.

Medically Necessary Repatriation: After initial treatment and stabilization for an Injury or Sickness, if the attending physician and the Travel Assistance Program's Medical Director deem it medically necessary, the Travel Assistance Program will transport you back to your permanent place of residence for further medical treatment or to recover. Services include arranging and paying for transportation and related medical services (including cost of medical escort, if necessary) and medical supplies necessarily incurred in connection with the repatriation.

Repatriation of Remains: In the event of your death, the Travel Assistance Program will render assistance and provide for the return of mortal remains. Services include arranging and paying for the following: location of a sending funeral home; transportation of the body from the site of death to the sending funeral home to the airport; minimally necessary casket or air tray for transport; coordination of consular services (in the case of death overseas); procuring death certificates; and transport of the remains from the airport to the receiving funeral home. Other services that might be performed in conjunction with those listed above include: making travel arrangements for any traveling companions; identification and/or notification of next-of-kin. Repatriation of Remains services are subject to a maximum coverage limit of \$25,000.

Visit by Family Member or Friend: If you are hospitalized for more than seven (7) days and are traveling alone, the Travel Assistance Program will arrange and provide your family member or friend with transportation to visit you. Visit by Family Member or Friend services are subject to a maximum coverage limit of \$5,000, to include one (1) round trip economy ticket, meals and reasonable accommodations up to a maximum of 10 days.

Return of Dependent Children: If you are hospitalized for more than seven (7) days, the Travel Assistance Program will arrange and pay for the return of your minor children who are under 19 years of age, and if necessary, accompany him or her with an attendant, up to a maximum coverage limit of \$5,000 per event.

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TRAVEL ASSISTANCE (continued from page 22)

Return of Traveling Companion: If your traveling companion loses previously made travel arrangements due to your medical emergency, the Travel Assistance Program will arrange and pay for your traveling companion's return home by the most direct and economical route, up to a maximum coverage limit of \$5,000 per event.

Assistance Services	Maximum Limit
Emergency Evacuation.....	Unlimited
Medically Necessary Repatriation	Unlimited
Repatriation of Remains	\$ 25,000
Visit by Family Member or Friend.....	\$ 5,000
Return of Dependent Children.....	\$ 5,000
Return of Traveling Companion.....	\$ 5,000

MEDICAL ASSISTANCE SERVICES

Medical Referrals: The Travel Assistance Program will assist you in finding physicians, dentists, and medical facilities.

Medical Monitoring: During the course of a medical emergency, the Travel Assistance Program's professional case managers, including physicians and nurses, will make sure the appropriate level of care is maintained or determine if further intervention, medical transportation, or possibly repatriation (return to U.S.) is needed. The Travel Assistance Program will provide case notification, both foreign and domestic, between the patient, family, physician, employer, travel company, and consulate as needed. The Travel Assistance Program will continue to provide all necessary international claim coordination, to include hospital bill translation and interpretation, as needed.

Emergency Medical Payments: When it is necessary for you to obtain needed medical services, upon request, the Travel Assistance Program will advance in local currency, up to \$10,000 to cover on-site medical expenses. The advance of funds will be made to the medical provider after the Travel Assistance Program has secured funds from you or your family.

Replacement of Medication and Eyeglasses: The Travel Assistance Program will arrange to fill a prescription that has been lost, stolen, or requires a refill, subject to local law, whenever possible. The Travel Assistance Program will also arrange for shipment of replacement eyeglasses. Costs for shipping of medication or eyeglasses, or a prescription refill, etc. are your responsibility.

Hotel Convalescence Arrangements: The Travel Assistance Program can assist you with hotel arrangements if you or your companion needs to convalesce in a hotel prior to or following medical treatment.

Medical Insurance Assistance: The Travel Assistance Program can assist you by coordinating notifications to medical insurers or managed care organizations, verifying policy enrollment, confirming medical benefits coverage, guaranteeing medical payments, assisting in the coordination of multiple insurance benefits, and handling claims paperwork flow.

Prescription Drug Assistance: When permitted by law and approved by the patient's physicians, the Travel Assistance Program will assist you in obtaining prescription drugs and other necessary personal medical items that may have been forgotten, lost or depleted while traveling.

LEGAL ASSISTANCE

Locating Legal Services: The Travel Assistance Program can assist in contacting a local attorney or the appropriate consular officer if you are arrested or detained, involved in an automobile accident, or otherwise need legal help. The Travel Assistance Program will maintain communications with you, your family, and employer until legal counsel has been retained by you.

Bail Bond Services: The Travel Assistance Program can assist in securing bail bond services in all available locations.

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TRAVEL ASSISTANCE (continued from page 23)

BAGGAGE ASSISTANCE

The Travel Assistance Program can assist you if your baggage is lost, stolen, or delayed while traveling on a common carrier. The Travel Assistance Program will advise you of the proper reporting procedures and will help you maintain contact with the appropriate companies or authorities to help resolve the problem.

EMERGENCY PAYMENT ASSISTANCE

The Travel Assistance Program can assist you in obtaining an advance of funds for medical expenses or other travel emergencies by coordinating directly with your family, or your credit card company, bank, employer, plan sponsor or other sources of credit.

PRE-TRIP ASSISTANCE

Pre-trip assistance is available at any time and is not subject to the 100-mile travel requirement.

Passport and Visa Information: The Travel Assistance Program can advise you of the required documentation to enter and depart foreign destinations.

Health Hazards Advisory: The Travel Assistance Program can provide you with up to date travel advisories.

Inoculation Requirements: Medical entry requirements can be provided to you prior to your departure.

Weather Information: The Travel Assistance Program maintains current information regarding weather conditions for both domestic and international travel destination. This information will be provided to you through the Travel Assistance Program Call Center.

Currency Exchange Information: The Travel Assistance Program can provide you with the daily currency exchange rate for a specified country.

Consulate and Embassy Locations: The Travel Assistance Program maintains a complete listing of consulates and embassies. These locations are accessible to you by calling the Travel Assistance Program Call Center.

Translation and Interpreter Services: Professional translators and interpreters can be reached 24-hours a day to obtain translation or interpreter assistance services during emergency situations while traveling internationally.

Travel Locator Service: You can contact the Travel Assistance Program Call Center 24 hours a day, seven (7) days a week, for assistance in locating hotels, airports, sports facilities, campgrounds, and tourist attractions.

EMERGENCY MESSAGE ASSISTANCE

The Travel Assistance Program can record emergency messages from you or emergency messages for you for 24-hour periods. These messages may be retrieved at anytime by you, your family, or business associates.

EMERGENCY CASH ASSISTANCE

The Travel Assistance Program can assist you with emergency cash up to \$500. Arrangements will be made through a friend, family member, business, or your credit card in the event of an emergency. All fees associated with the transfer or deliveries of funds are your responsibility.

EMERGENCY TICKET REPLACEMENT

The Travel Assistance Program can assist you in replacing lost or stolen airline tickets.

EMERGENCY CARD REPLACEMENT

The Travel Assistance Program can assist you with emergency card replacement if you should experience a loss, theft, or damage to your credit card or membership card.

EXCLUSIONS AND LIMITATIONS

1. The Travel Assistance Program shall not provide services enumerated if the coverage is sought as a result of: a) involvement in any act of war, invasion, acts of foreign enemies, hostilities (whether war is declared or not), civil war, rebellion, revolution, and insurrection, military or usurped power; b) traveling against the advice of a physician; traveling for the purpose of obtaining medical treatment; c) traveling

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TRAVEL ASSISTANCE (continued from page 24)

in any country in which the U.S. State Department issued travel restrictions; d) the commission of or attempt to commit an unlawful act; e) mental or emotional disorders, unless hospitalized; f) participation as a professional in athletics; g) services provided for you for which no charge is normally made; or h) travel within 100 miles of your primary residence, unless in a foreign country.

2. The services described above currently are available in every country of the world. Due to political and other situations in certain areas of the world, the Travel Assistance Program may not be able to respond in the usual manner. It is your responsibility to inquire whether a country is "open" for assistance prior to your departure and during your stay. The Travel Assistance Program also reserves the right to suspend, curtail or limit its services in any area in the event of rebellion, riot, military uprising, war, terrorism, labor disturbance, strikes, nuclear accidents, acts of God or refusal of authorities to permit the Travel Assistance Program to fully provide services.
3. If you request a transport related to a condition that has not been deemed medically necessary by a physician designated by the Travel Assistance Program in consultation with a local attending physician or to any condition excluded hereunder, and you agree to be financially responsible for all expenses related to that transport, the Travel Assistance Program will arrange but not pay for such transport to a medical facility or to your residence and will make such arrangements using the same degree of care and completeness as if the Travel Assistance Program was providing service under this agreement. A waiver of liability will be required prior to arranging these transportation services.
4. The Travel Assistance Program shall not be responsible for any claim, damage, loss, costs, liability or expense which arises in whole or in part as a result of the Travel Assistance Program's inability to verify the participant's eligibility.

All transportation benefits provided hereunder must be by the most direct and economical route possible.

For the purposes of this description of covered services, the following definitions shall apply: 1) "Injury" means identifiable injury caused by an Accident; 2) "Accident" means a sudden, unexpected, unusual, specific event which occurs at an identifiable time and place; 3) "Sickness" means a sickness of the participant which declares itself during the period when services are available under this Agreement.

The Travel Assistance Program is not responsible and cannot be held liable for any malpractice performed by a local physician or attorney who is not an employee of the Travel Assistance Program, or for any loss or damage to your vehicle during the return of the vehicle, or for any loss or damage to any personal belongings.

NATIONWIDE LIFE HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply to Nationwide Life Insurance Company®, National Casualty Company, and the area within Nationwide Mutual Insurance Company® that performs healthcare functions. In this Notice, “Nationwide Life” or “We” means the healthcare functions of Nationwide Life Insurance Company, which is a hybrid covered entity (the healthcare functions of National Casualty Company, and Nationwide Mutual Insurance Company, a business associate). As permitted by law, Nationwide Life will share protected health information (PHI) of members as necessary to carry out treatment, payment, and healthcare operations.

We are required by HIPAA and certain state laws to maintain the privacy of our members’ PHI and to provide members with notice of our legal duties and privacy practices with respect to their PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. Copies of the revised notices will be mailed to all current plan members or insureds.

Protected health information (PHI) that is the subject of this Notice is information that is created or received by Nationwide; and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. It includes information of persons living or deceased.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your PHI for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing, unless we have taken any action in reliance on the authorization.

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your PHI without your authorization. We may release your PHI for any purpose required by law. This may include releasing your PHI to law enforcement agencies; public health agencies; government oversight agencies; workers compensation; for government audits, investigations, or civil or criminal proceedings; for approved research programs; when ordered by a court or administrative agency; to the armed forces if you are a member of the military; and other similar disclosures we are required by law to make. We may release your PHI to your plan sponsor, provided your plan sponsor certifies that the information provided will be maintained in a confidential manner and not used in any other manner not permitted by law.

OTHER PRIVACY LAWS AND REGULATIONS

Certain other state and federal privacy laws and regulations may further restrict access to and uses and disclosures of your personal health information or provide you with additional rights to manage such information. If you have questions regarding these rights, please send a written request to your designated contact.

RIGHTS THAT YOU HAVE

Access to Your Protected Health Information. You have the right to copy and/or inspect much of the PHI that we retain on your behalf. All requests for access must be made in writing and signed by you or your personal representative. We may charge you a fee if you request a copy of the information. The amount of the fee will be indicated on the request form. A request form can be obtained by writing your designated contact.

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HIPAA NOTICE (continued from page 26)

Amendments to Your Protected Health Information. You have the right to request that the PHI that we maintain about you be amended or corrected. We are not obligated to make all requested Amendments but will give each request careful consideration. If the information is incorrect or incomplete and we decide to make an amendment or correction, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. A request form can be obtained by writing to your designated contact.

Accounting for Disclosures of Your Protected Health Information. You have the right to receive an accounting of certain disclosures made by us of your PHI. Requests must be made in writing and signed by you or your personal representative. A request form can be obtained by writing your designated contact.

Restrictions on Use and Disclosure of Your Protected Health Information. You have the right to request restrictions on some of our uses and disclosures of your PHI. We are not required to agree to your restriction request. A request form can be obtained by writing your designated contact.

Disclosures for Treatment, Payment and Health Care Operations. We will make disclosures of your PHI as necessary for your treatment, payment, and/or health care operations. For instance, for your Treatment, a doctor or health facility involved in your care may request information we hold in order to make decisions about your care. For Payment, we may disclose your PHI to our pharmacy benefit manager for administration of your prescription drug benefit. For Health Care Operations, we will use and disclose your PHI as necessary, and as permitted by law, for our health care operations, which include responding to customer inquiries regarding benefits and claims.

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your PHI to designated family, friends, and others who are involved in your care or in payment for your care in order to facilitate that person’s involvement in caring for you or paying for your care.

If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited PHI with such individuals without your approval.

Business Associates. Certain aspects and components of our services are performed through contracts with outside persons or organizations. At times it may be necessary for us to provide some of your PHI to one or more of these outside persons or organizations. In all cases, we require these business associates by contract to appropriately safeguard the privacy of your information.

Other Health-Related Products or Services. We may, from time to time, use your PHI to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products, or services which may be available to you as a member of the health plan. For example, we may use your PHI to identify whether you have a particular illness, and advise you that a disease management program to help you manage your illness better is available to you. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

Information Received Pre-enrollment. We may request and receive from you and your health care providers PHI either prior to your enrollment in the health plan or the issuance of your policy. We will use this information to determine whether you are eligible to enroll in the health plan and to determine your rates. We will protect the confidentiality of that information in the same manner as all other PHI we maintain and, if you do not enroll in the health plan we will not use or disclose the information about you we obtained without your authorization.

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HIPAA NOTICE (continued from page 27)

Communications With You. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your PHI information from us by alternative means or at alternative locations. A request form can be obtained by writing your designated contact.

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with your designated contact as explained in the "Contact Information" section, below. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights, in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

CONTACT INFORMATION

If you have any questions about this statement, need copies of any forms or require further assistance with any of the rights explained above, contact us by calling 1-877-955-1559, or mail your request to:

Karen Maciejewski
Privacy Officer
AmeriBen
3449 East Copper Point Drive
Meridian, ID 83642

As a member, you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

EFFECTIVE DATE

This Nationwide Life HIPAA Notice of Privacy Practices is effective April 14, 2003.

CERTIFICATION OF QUALIFYING HEALTH PLAN COVERAGE

If you are no longer eligible to be insured under the plan, you should request a Certification of Qualifying Health Plan Coverage from Renaissance Insurance Agency, Inc. This request can be made by phone or in writing. This request must include the name of the school and the name of each person who is no longer eligible to be insured under the plan.

AUTHORIZED REPRESENTATION

In accordance with state and federal rules and regulations, we will not disclose individual information without authorization. This includes disclosures to family members for insured individuals who have reached the age of majority.

If you would like to authorize an additional party to act as a personal representative for matters pertaining to this insurance plan, we must have an Authorization Form on file. To request a form, please contact Renaissance Insurance Agency, Inc. at the address below or complete a form via the Internet at: www.renstudent.com.

SUMMARY OF PRIVACY POLICY

We strongly believe in maintaining the confidentiality of the personal information we obtain and/or receive about Insured Persons and we are committed to protecting the privacy of Insured Persons. We do not disclose any nonpublic information about Insured Persons to anyone, except as permitted or required by law. We do not sell or otherwise disclose Insured Person's personal information to anyone for purposes unrelated to our products and services. We maintain physical, electronic and procedural safeguards that comply with federal and state regulations to protect information about Insured Persons from unauthorized disclosure. We may disclose any information we believe necessary to conduct our business as is legally required. Insured Persons have the right to access, review and correct all personal information collected. Insured Persons may review this Privacy Policy in its entirety, or the Privacy Policies of other entities servicing the Policy, by writing to the address or visiting the website shown below. Insured Persons may also submit a request, in writing, to review your information at the address below.

Attention: Privacy Manager
Renaissance Insurance Agency, Inc.
P.O. Box 2300
Santa Monica, CA 90407-2300
Phone: 1-800-537-1777
Facsimile: 1-310-394-0142
Website: www.renstudent.com

INSURANCE ID CARD

A temporary ID Card can be downloaded at www.renstudent.com/isu. A permanent ID card will be mailed to you shortly after the beginning of the Fall Semester. Only one permanent ID card will be mailed to you each school year (not each semester). If you need a replacement card, please contact AmeriBen at 1-877-955-1559. **Always carry your insurance ID card with you.**

IMPORTANT INFORMATION

This brochure describes your benefits under the plan of insurance sponsored by your school. It is not a contract of insurance. Your coverage is governed by a policy of blanket Injury and Sickness insurance underwritten by Nationwide Life Insurance Company. As evidence of your coverage, a policy of insurance (Policy Number 302-110-1109) has been issued to your school which contains the benefits and provisions which apply to the plan of insurance sponsored by your school. Any discrepancy between this brochure and the policy will be governed by the policy. Please keep this brochure for future reference.

NSHSAS 2000 ID

Insurance Company:
Nationwide Life Insurance Company

Policy Number:
302-110-1109

Student Insurance Office:
921 South 8th Avenue, Stop 8375
Pocatello, ID 83209
1-208-282-2972

For questions regarding eligibility, benefits or claims, contact:

AmeriBen
P.O. Box 6947
Boise, ID 83707-0947
Toll-Free 1-877-955-1559
www.myameriben.com

For travel assistance services 24/7, contact:

On Call International
From US or Canada: 1-866-525-1957
Collect from anywhere else in the world: 1-603-898-9159
Email: mail@oncallinternational.com

**To download additional plan materials or an FAQ,
or to enroll Dependents in the plan, please visit:**
www.renstudent.com/isu