
2010-2011

Designed Especially for the Students of



Student Health Insurance Plan



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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your non-public personal information. We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your non-public personal information. You may obtain a copy of our privacy practices by calling toll-free at 800-767-0700 or visiting www.uhcsr.com.

Introduction

This is The Ohio State University Comprehensive Student Health Insurance Plan (Plan). This health benefits plan has been specifically designed for students of The Ohio State University (OSU). Gallagher Koster has been selected to service the OSU Student Health Insurance Plan. Gallagher Koster is the account manager and is responsible for the overall servicing of the Plan. If you have any questions on eligibility, enrollment, available benefits or general service issues, you should contact Gallagher Koster's dedicated toll-free phone number, 1-800-254-2461, or email address, OSUship@Gallagherkoster.com.

It is important that you retain this booklet for a complete description of coverage provided through the Plan. Knowing the terms of this Coverage is your responsibility and not the responsibility of the health care provider. Questions regarding Coverage should be referred to the Gallagher Koster customer service department. The Plan has five major benefit components that are outlined below and described in detail in this Plan Description:

1. Coverage for services rendered by OSU Student Health Services at the Wilce Student Health Center;
2. Coverage for services rendered by OSU Counseling and Consultation Service at the Younkin Success Center;
3. Coverage for services rendered by providers participating in the Ohio State University Health Plan, Inc. Network (OSU Health Plan) Provider Network, locally, and by the UnitedHealthcare Options PPO Provider Network, outside of Franklin County and nationally;
4. Coverage for services rendered by Providers that do not participate in the OSU Health Plan or UnitedHealthcare Options PPO networks;
5. Coverage for the Emergency Medical Evacuation/Repatriation of Remains and Emergency Travel Assistance Benefits offered through Scholastic Emergency Services Global Emergency Medical Assistance.

All medical insurance plan benefits, except for services rendered by Student Health Services at the Wilce Student Health Center, Counseling and Consultation Service at the Younkin Success Center, Delta Dental, and Scholastic Emergency Services, are underwritten by UnitedHealthcare Insurance Company (The Company). Benefits for services rendered by Student Health Services at the Wilce Student Health Center, the Counseling and Consultation Service at the Younkin Success Center, and the College of Optometry are self-funded by OSU.

The Company issues this Plan Description according to the terms of the Master Policy (Policy). It contains some of the provisions of the Master Policy. If there is any misunderstanding or inconsistency between the Plan Description and the Master Policy, the actual terms of the Master Policy shall govern. The Master Policy is between The Company and The Ohio State University. OSU is the Policyholder under the Master Policy.

On behalf of an Insured Person, OSU collects the premium required under the Plan and makes such payments as due to The Company. The Student Health Insurance Program, Office of Student Life is responsible for making any changes in coverage, terminating coverage, and doing any other acts required to make your coverage active. It is the responsibility of each student to add Dependents when a qualifying event occurs during the School Term and to pay prorated premiums.

All persons who have satisfied the eligibility conditions and have not waived coverage according to the terms of this Plan Description, are covered by this Plan.

Special Points to Consider

This is a brief summary on key provisions. Refer to the specific section for a complete explanation.

- **Insurance Requirements.** All Columbus campus-based domestic students who are enrolled at least half time are required to be insured by either The Ohio State University Comprehensive Student Health Insurance Plan or a health insurance plan of comparable coverage. Students attending regional campuses are not required, but are eligible to purchase the Comprehensive Student Health Insurance Plan. In addition, all international students are required to be insured under the Comprehensive Student Health Insurance Plan as a condition of enrollment.
- **Importance of Maintaining Continuous Coverage.** Students and their Dependents who want to maintain coverage will need to purchase coverage for an Off-Term, or risk a lapse in coverage. Should your coverage lapse, you will not be covered by the Plan until you re-purchase the Plan. Keep in mind that a lapse in coverage requires you to re-satisfy the Pre-Existing Condition Waiting Period.
- **Pre-Existing Condition Limitation.** A Pre-Existing Condition is any condition for which the Insured Person received diagnosis, advice or treatment, including prescription drugs, during the three-month period immediately prior to the effective date of the Insured Person's coverage. Claims for a Pre-Existing Condition will be covered once the individual has been covered under the Plan for three (3) consecutive months. This consecutive three (3) month period is known as the Pre-Existing Condition Waiting Period. Pregnancy is covered as any other condition and will be subject to the Pre-Existing Condition Limitation. If the Insured Person or covered Dependent has any lapse in coverage the Pre-Existing Condition Waiting Period must be resatisfied. Therefore, students are encouraged to maintain continuous coverage including Off-Terms. The Pre-Existing Condition Waiting Period will be waived for services covered under the OSU Student Health Services and OSU Counseling and Consultation Service benefits.
- **Pre-Certification Requirement/Utilization Review.** There are several benefits that require pre-certification in order for these services to be paid in accordance with plan provisions. Please refer to page 31-33 for a complete description of the pre-certification requirements.
- **Maintaining Student Information.** Various methods are used to expedite students' receipt of plan information and updates on a timely basis. ID cards, Explanation of Benefits, etc. are mailed to students at the address on file with Ohio State. Reminder notices and important announcements on the Student Health Insurance Plan are sent via students' OSU email address. It is your responsibility to make sure your address(es) are accurate at www.buckeyelink.osu.edu.
- **Conversion Plan.** You may convert to the Conversion Plan after Off-Term Coverage is exhausted. In order to enroll in this option, you had to be enrolled in the Student Health Insurance Plan for at least 6 months and you must apply for and purchase the Conversion Plan within 31 days following the date you lose eligibility under the Student Health Insurance Plan. This plan has a completely separate benefit, pre-existing condition limitation and rate structure. Contact Gallagher Koster at 1-800-254-2461 or OSUship@Gallagherkoster.com for details.

Student Eligibility and Enrollment

Student Eligibility – Domestic Students

All Domestic Students who are enrolled in a degree program at OSU at least six (6) credit hours for undergraduates, at least five (5) credit hours for graduate students and at least three (3) credit hours for post-candidacy doctoral students are eligible under this Plan. Exceptions apply to enrolled students taking one of the approved exception course numbers representing co-ops, internship, study abroad, and thesis or dissertation research. These students will be automatically charged and the health insurance premium will be included in their fees, unless the student waives coverage.

Credit Hour Requirements

The following courses are excluded from being applied towards the minimum credit hours:

- Courses taken as Non-degree. The following Programs or Plans are considered non-degree: Graduate Non-degree, Graduate Visitor, Undergraduate Non-degree, Undergraduate Visitor, Undergraduate Academy, Law Non-degree, Law Casual.

Students may petition for an exception if:

The course is a pre-requisite for entrance into a degree status program of study; and

If the course is graduate level, the student has a current application on file with the Graduate School.

- Distance Learning courses (as denoted by “mode of instruction”). Students may petition to use distance learning hours for eligibility if taken in conjunction with on-campus courses.
- Courses designated as Continuing Education.
- Courses taken as Audit.
- Courses taken as Pass/Non-Pass in excess of the 15 credit hours allowed by the University to count toward a degree program.

Students who do not meet the minimum credit hour requirements are not eligible to purchase the Comprehensive Student Health Insurance Plan, and can contact Gallagher Koster at 1-800-254-2461 or OSUship@Gallagherkoster.com for possible alternative options.

Student Eligibility - International Students

International Students are required to enroll in the Comprehensive Student Health Insurance Plan as a condition of enrollment at OSU. International Students can not waive coverage unless they are currently enrolled in a comparable insurance plan provided through an approved government-sponsored program or an international organization, or are a covered dependent of a U.S. based employee.

International Students who fall under one of these categories must request an exemption by completing an International Student Health Insurance Waiver Form and submitting it prior to the deadline to: Student Health Insurance Program, 1100 Lincoln Tower, 1800 Cannon Drive, Columbus, OH 43210.

Enrollment Requirements

All eligible domestic students who enroll in the Student Health Insurance Plan in the Autumn quarter are automatically enrolled for Annual coverage, which includes the Autumn, Winter, Spring, and Summer Terms. All eligible domestic students who initially enroll in the Winter Term, are automatically enrolled for Winter, Spring, and Summer Terms, and all eligible domestic students who initially enroll in the Spring Term, are automatically enrolled in the Spring and Summer Terms.

Please note: In order to be covered automatically for any term, including Summer Term, students must remain enrolled in classes that meet the Student Health Insurance Plan eligibility requirements.

Graduate students who receive a premium subsidy from the University, must maintain at least the minimum number of credit hours and work hours each quarter, and remain in an eligible appointment as defined by the Graduate School to continue to receive the subsidy.

Purchasing/Waiving Coverage

This process does not apply to International Students. International Students, please refer to "Student Eligibility – International Students".

It is the student's responsibility to purchase or waive coverage. The charge for single, Comprehensive Student Health Insurance will be automatically applied to a student's Statement of Account during the course registration process as part of University Fees, unless an On-Line Waiver Form is completed by the deadline. Students who are currently enrolled in a plan of comparable coverage can waive the Comprehensive Student Health Insurance Plan. Students must waive coverage online through (<http://www.buckeyelink.osu.edu>). Students, upon their initial eligibility, have until the deadline (refer to page 8 for the Enroll or Withdraw Deadline Schedule), as published at www.shi.osu.edu, to waive Student Health Insurance coverage. When a student waives coverage by the deadline, coverage is waived for the remainder of the school terms of that policy year for which the student is eligible.

All eligible domestic students who waive out of the Comprehensive Student Health Insurance Plan will need to provide proof of comparable, major medical coverage. If this documentation cannot be provided, students will remain enrolled in the Comprehensive Student Health Insurance Plan up to a maximum of three consecutive terms. All requests to waive the Comprehensive Student Health Insurance Plan received after the deadline of a student's initial term of enrollment in the academic year, for whatever reason, require an appeal to be filed. Petitions to waive coverage must be submitted within 12 months from the the last day of coverage of the policy year; petitions received after this date will not be accepted.

Academic transactions processed between the first day of coverage up to the 5th Friday of the term, that result in loss of eligibility will automatically dis-enroll the student from coverage for the entire term. Upon request, the student can convert to Off-Term coverage if eligible.

Students who fall below the minimum credit requirement can convert to Off-Term coverage, if eligible.

Off-Term Coverage

Coverage may be continued without interruption for one consecutive School Term per Policy Year for all Insured Students who: 1) graduate, or 2) are not enrolled in classes, or 3) are enrolled in classes, but who have dropped below the minimum credit hour requirement (6 credit hours for undergraduate and 5 credit hours for graduate students), or 4) do not meet other eligibility criteria, provided they were enrolled in class and covered by the plan during the preceding School Term. Please refer to "Credit Hour Requirements" on page 3 for the list of courses that are excluded from being applied to the minimum credit hour requirement. Coverage for an Off-Term is not automatic.

Students who convert to off-term due to an approved medical withdrawal, may be eligible for an additional off-term coverage. Contact the OSU Student Health Insurance Program to request a petition.

NOTE: Graduating students must make their Off-Term selection by the day immediately preceding commencement.

Please refer to the section entitled, "Coverage Dates" on page 8 to confirm term coverage dates. **YOU WILL NOT AUTOMATICALLY BE BILLED FOR OFF-TERM COVERAGE AND ARE REQUIRED TO ACTIVELY ENROLL FOR OFF-TERM COVERAGE.** Students who are eligible to purchase off-term insurance can do so at: <http://www.buckeyelink.osu.edu> by the deadline.

Coverage Status

There are four types of coverage status available for students who have enrolled in the Comprehensive Student Health Insurance Plan:

1. Student;
2. Student and Spouse/Domestic Partner;
3. Student and Child(ren);
4. Student, Spouse/Domestic Partner, and Child(ren).

The default coverage status is for a single Student Only. Students who want to change their coverage status must change coverage online through (<http://www.buckeyelink.osu.edu>). The deadline for Students to change their Student Health Insurance Coverage Status is the first term of enrollment each policy year.

Students are required to remain in the same coverage status initially selected upon enrollment, each policy year, for each term Student Health Insurance is purchased between Autumn 2010 and Summer 2011, unless the student experiences a qualifying event.

Qualifying Event Exception:

The Student must meet minimum eligibility requirements for the term of the qualifying event. A Qualifying Event is defined as an event that could result in a change of Coverage Status and includes: 1) marriage, divorce, or initially meeting requirements of domestic partnership, 2) child birth or adoption, 3) death, 4) dependent reaching the age limit of another health insurance plan, 5) first time arrival of dependent(s) to the United States from a foreign homeland, 6) a gain of coverage as the result of the student becoming employed, 7) open enrollment of the student, parent or spouse's employer plan, 8) a change in the student, parent or spouse's employment status resulting in the eligibility for benefits or the involuntary loss of coverage, and 9) attainment of minimum eligibility requirements after the 5th Friday of the term.

If a student experiences a qualifying event, the student must complete and submit a Coverage Status Change Form along with supporting documentation to Gallagher Koster within 31 days of the qualifying event. If a student experiences a qualifying event during a term that the student is not enrolled, a Coverage Status Change Form along with supporting documentation should still be sent to Gallagher Koster within 31 days of the qualifying event but the effective date of the requested change will be the first day of the term in which the student returns to The Ohio State University.

If the Coverage Status Change Form representing a request to add is made in accordance with this plan, the student must meet the minimum eligibility requirements. If the request is approved by Gallagher Koster, the coverage will be retroactive to the date of the qualifying event.

If the Coverage Status Change Form to terminate coverage is made in accordance with the Plan and approved by Gallagher Koster, the termination will be effective the first day of the following term and there will be no pro-rata refund of premium (during the term of the Qualifying Event).

If a student misses the 31 day deadline, the next opportunity to change Coverage Status will be at the beginning of the next plan year.

Interim Coverage: Special Provisions

Special provisions are made for Medical (MED I) students, new graduate and professional students enrolling in the University for the first time, and International Students arriving early to begin their studies. Coverage will begin 30 days prior to the effective date of the Autumn Quarter. An interim prorated premium will be billed to the University Statement of Account for coverage from 8/09/10-9/14/10.

Dependent Eligibility and Enrollment

The student is responsible for ensuring that Dependents are eligible for coverage according to the terms set forth in this Plan Description by submitting a Dependent Enrollment online through <http://www.buckeyelink.osu.edu>. A Coverage Status Change Form may also need to be submitted to Gallagher Koster and the Affidavit of Domestic Partnership, if appropriate, to the Student Health Insurance Program Office (see the section entitled "Policy Terms"). The Company reserves the right to confirm eligibility for dependent coverage. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium. Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student.

A Dependent is:

1. The Insured Student's legal spouse or Domestic Partner.

The definition of Domestic Partner includes same-sex domestic partners and opposite-sex domestic partners. Domestic partners: 1) must share a permanent residence (unless residing in different cities, states or countries on a temporary basis); 2) are each other's sole domestic partner, have been in this relationship for at least six (6) months, and intend to remain in this relationship indefinitely; 3) are not currently married to or legally separated from another person under either statutory or common law; 4) are responsible for each other's common welfare; 5) are at least eighteen (18) years of age and mentally competent to consent to this contract; 6) are not related by blood to a degree of closeness that would prohibit marriage in the state in which they legally reside; 7) are either a) financially **interdependent** on each other if same-sex domestic partners in accordance with the plan requirements outlined by Ohio State and the Comprehensive Student Health Insurance Plan, or b) are financially **dependent** on each other if opposite-sex domestic partners in accordance with the plan requirements outlined by Ohio State and the Comprehensive Student Health Insurance Plan.

2. The Insured Student's unmarried children under the age of nineteen years. The term "Children" includes an Insured Student's biological children; step-children; foster children; adopted children from the date of placement in the Insured Student's home and who depend on the Insured Student for their support; children which the Insured Student has been granted legal custody; children which the Insured Student has legal obligation to provide coverage due to a court order, and children of the Domestic Partner who reside with the Insured Student and for whom the Insured Student or Domestic Partner is responsible to provide coverage.

The Named Insured may cover a dependent child until the age of twenty-eight (28) years, if all of the following are true:

- 1) The child is the natural child, stepchild, or adopted child of the Named Insured.
- 2) The child is a resident of this state or a full-time student at an accredited public or private institution of higher education.

- 3) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage.
- 4) The child is not eligible for coverage under the Medicaid program established under Chapter 5111 of the Revised Code or the Medicare program established under Title XVIII of the "Social Security Act," 42 U.S.C. 1395.
3. A child born to an Insured Student while this Plan is in force will be covered by this Plan. Coverage for such newborn children will consist of coverage for Sickness or Injury including necessary care or treatment of congenital defects, birth abnormalities, premature birth, or nursery care. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage (i.e. Student/Child, Student/Spouse or Domestic Partner/Child) when the child is born. However, the student is still responsible for notifying Gallagher Koster in order to continue that dependent's coverage beyond the first 31 days from the moment of birth. If the Insured Student does not have dependent coverage when the child is born, the newborn child is covered for dependent benefits for the first 31 days from the moment of birth. To continue the child's dependent benefits past the first 31 days, the Insured Student must contact Gallagher Koster to obtain a Coverage Status Change Form and submit it and the required premium to Gallagher Koster within 31 days of the child's birth.
4. A child's coverage will not end because the child has reached the age limit of nineteen (19) years shown above, if he or she: (a) is not able to earn his or her own living as a result of physical or mental incapacity; and (b) became so incapacitated before reaching the age limit; and (c) is mainly dependent on the Insured Student for support and maintenance. Within 31 days of the child reaching the age limit, the Insured Student must send Gallagher Koster proof of the child's dependency or handicap. Additional proof of the child's dependency and handicap may be requested, but not more frequently than annually after the two year period following the child's attainment of the age limit.
5. Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Plan.

Dependent Enrollment

It is the student's responsibility to ensure the timely enrollment and re-enrollment of their eligible dependents. Students are required to enroll their eligible dependents by the deadline in order to have dependent coverage begin at the beginning of that coverage period and to avoid a lapse in coverage if enrolling previously insured Dependents. To enroll an eligible dependent, the student must elect coverage online through <http://www.buckeyelink.osu.edu>.

Coverage Status Change Forms and Affidavits of Domestic Partnership are available from the Student Health Insurance Program Office or online at www.Gallagherkoster.com, click on "College and University Students" and select "The Ohio State University" from the drop down menu. The Affidavit must be returned to the Student Insurance Program Office 1100 Lincoln Tower.

With the exception of Dependents who become eligible during the School Term (after the Insured Student's effective date), coverage for Dependents becomes effective on the same date as that of the Insured Student. All claims for Dependents can not be processed until receipt of the appropriate form(s).

Late Dependent Enrollment

If eligible Dependents are not enrolled by the deadline and you need to add eligible Dependents during the school term, the following procedures apply:

Marriage: If you marry and wish to purchase Dependent Coverage, you must complete a Coverage Status Change Form, including the appropriate documentation. Submit these completed forms to Gallagher Koster within 31 days of the date of marriage in order for Coverage for your spouse to become effective on the date of marriage.

Domestic Partner: Insured students who want to enroll their Domestic Partner are required to complete a Coverage Status Change Form along with a signed and notarized Affidavit of Domestic Partnership. Submit both completed forms to the Student Health Insurance Program Office, 1100 Lincoln Tower.

Birth or Adoption: If you acquire a Dependent child (through birth, adoption, guardianship decree or a domestic partnership) and wish to cover this child, you must complete and submit a Coverage Status Change Form, including the appropriate documentation to Gallagher Koster within 31 days of the date you acquire the child in order for Coverage for the Dependent child to become effective on the date of birth, adoption or guardianship decree.

Arrival of Dependents from a Foreign Homeland: If your Dependent(s) will be arriving from a foreign homeland for the very first time, you must complete and submit a Coverage Status Change Form, including the appropriate documentation to Gallagher Koster within 31 days from your Dependent's arrival from the foreign homeland in order for Coverage for the Dependent to become effective on the date of the Dependent's arrival following direct travel from the foreign homeland.

Payment for Late Dependent Enrollment

For all late Dependent enrollments, students will be advised of the prorated premium, if applicable. Any applicable premium will be billed to the University Statement of Account.

If you do not add a new Dependent within 31 days of the date the Dependent initially becomes eligible for coverage, you must wait until the following Autumn Term to add the Dependent for coverage.

Coverage Terms and Costs

The registration process automatically registers a student in the Comprehensive Student Health Insurance Plan with Student-Only coverage. The premium for the coverage will appear on your University Statement of Account each eligible term unless waived.

Coverage may not be purchased after the deadline of each School Term as established by OSU. These dates are as follows:

Coverage Term

Quarter Students	Coverage Dates	Enroll or Withdraw Deadline*
Autumn 2010	09/15/10 – 01/02/11	09/14/10
Winter 2011	01/03/11 – 03/27/11	01/02/11
Spring 2011	03/28/11 – 06/19/11	03/27/11
Summer 2011	06/20/11 – 09/13/11	06/19/11

Semester (Law) Students	Coverage Dates	Enroll or Withdraw Deadline*
Autumn 2010	08/16/10 – 01/09/11	08/09/10
Winter 2011	01/10/11 – 05/15/11	01/09/11
Summer 2011	05/16/11 – 08/14/11	05/15/11

*Students may only withdraw in the 1st term of enrollment each academic year.

The insurance under The Ohio State University's Comprehensive Student Health Insurance Plan for the Annual Policy Year begins on September 15, 2010. The Annual Policy terminates on September 13, 2011 or at the end of the period through which premiums are paid. The specific dates for each School Term are outlined above.

Unless fees are refunded due to waiver or withdrawal from class prior to the deadline, coverage remains in effect during the School Term in which the student is enrolled at OSU even if the student leaves school after the deadline.

This is a Non-Renewable One Year Term Policy.

***Coverage Costs**

	\$ Per Quarter / Off-Term		\$ Per Semester (Law)	
	Domestic	International	Domestic	International
Student	\$ 543.00	\$ 506.00	\$ 815.00	\$ 759.00
Student + Spouse or Domestic Partner	\$ 1,591.00	\$ 1,476.00	\$ 2,387.00	\$ 2,214.00
Student + All Children	\$ 1,613.00	\$ 1,495.00	\$ 2,420.00	\$ 2,243.00
Student + All Dependents	\$ 2,178.00	\$ 2,019.00	\$ 3,267.00	\$ 3,029.00

**Includes Medical, Dental and Vision Coverage.*

Fees are due on the first day of classes unless otherwise noted on the Statement of Account. Unpaid fees will result in a negative service indicator being placed on the student's record.

Premium Refunds

Coverage will be terminated and any premium paid will be refunded on the student's account up through the 5th Friday of the school term if the student waives coverage, drops below eligible credit hours or withdraws from classes. For students withdrawing from the University after the 5th Friday of the term, health insurance premiums will not be refunded unless specifically requested through an appeal and accompanied by a written statement verifying that no claims have been filed and/or paid. However, should an Insured Person receive a premium refund and claims were paid, the Company has the right to recover benefit payments made in connection with Covered Expenses incurred after the dates of termination under this policy. In addition to the above premium refund terms, there is no pro-rata of refunds unless the Insured enters the Armed Forces and requests a pro-rated refund.

Student Health Services Benefits

Student Health Services at The Ohio State University is located on the Columbus campus in the Wilce Student Health Center at 1875 Millikin Road. This fully accredited facility serves the students of The Ohio State University. The services available at the Wilce Student Health Center are separate from the benefits available through the Student Health Insurance Plan.

After Student Health Service hours students should utilize the OSU Hospital's Emergency Department or any other Network Urgent Care Facilities or their own OSU Health Plan provider if after hours care is available.

Students are not required to complete a claim form for services rendered at Wilce Student Health Center under this portion of the coverage. Student Health Services will file a claim on behalf of the student for services rendered at Wilce Student Health Center if the service is eligible for consideration under the Student Health Insurance Benefits. It is the student's responsibility to verify that a claim has been filed.

To maximize coverage, students covered by the Student Health Insurance Plan should first seek medical care at the Wilce Student Health Center for non-emergency conditions. Only students enrolled in the Student Health Insurance Plan are eligible for this portion of the coverage. This means that if you are enrolled as a Dependent, even if you are a student, services will not be covered under Student Health Services benefits, but are eligible for in-network coverage.

Outpatient Services received outside of the Wilce Student Health Center are not covered under this portion of the Plan.

Maximum Benefits for Medical Services & Prescription Drugs. The annual maximum benefit for medical services is \$2,000 and the annual maximum benefit for prescription drugs is \$500. There are individual annual benefit maximums for various Covered Services that accumulate to the annual maximum limit. Once you have exhausted this annual maximum, coverage for all Covered Services will no longer be provided under this portion of the Plan. This applies even if you have not utilized the individual maximum benefits. Covered Services in excess of the annual maximum may be considered under the Network or Non-Network benefit, and subject to the Pre-Existing Condition Limitation.

Covered Services. Coverage is limited to Medically Necessary services (as determined by the Student Health Services and subject to approval by the Student Health Insurance Program), except for covered preventive services. Covered Services will not be subject to the Pre-Existing Condition limitations up to the annual maximum limit. However, Covered Services in this section may be subject to special limits that do not apply to the Student Health Insurance Benefits. Refer to the Schedule of Benefits for details.

Outpatient Services. The following Outpatient Services include the procedures listed below when rendered for an Insured Student at the Wilce Student Health Center. Offered services vary according to student demand and availability of specialists within the community.

1. Office Visits.
2. Diagnostic Services. Includes routine x-rays, electrocardiograms, pathology and laboratory tests.
3. Outpatient Surgery. Outpatient surgery is limited to suturing, selected dermatological procedures and colposcopy.
4. Complementary and Alternative Medicine Services: Includes physical therapy, athletic training, osteopathic manipulative treatment, acupuncture and medical massage therapy.

5. Medical Nutrition Therapy.

6. Medical Supplies. Durable Medical Equipment and Custom Orthotics. Supplies in regular stock at Student Health Services are covered if they are prescribed and received as a component of treatment rendered by a Student Health Services provider. Coverage is provided for one custom orthotic per plan year.

Prescription Drugs. Coverage is provided for prescription drugs when in regular stock (in the formulary) dispensed by the Student Health Services pharmacy. There is a 34 day supply limit per prescription drug. Oral contraceptives may be dispensed in one-month quantities per number of months remaining in the academic term, up to a 90-day supply.

Preventive Services. Coverage is provided to the benefit maximum per academic year. Preventive Services include the services below when rendered for an Insured Student at the Wilce Student Health Center.

1. Immunizations.

a. When recommended by the Advisory Committee of Immunization Practices (ACIP)-recommended vaccines for Teen/Adult to include: Influenza, Hepatitis A, Hepatitis B, Td/Tdap, IPV (Polio), Varicella, Meningococcal, MMR, HPV.

b. When required for students to participate in academic programs of The Ohio State University.

c) When required for students traveling abroad.

2. Sexual Health Screen. Includes testing for Syphilis, Chlamydia, HIV and other tests based on patient history. Coverage is provided for one screening per plan year.

3. Gynecological Examination and Related Tests: Coverage is provided for one routine gynecological exam and pap smear test per plan year.

4. Allergy Injections. Allergy injections are covered when rendered by Student Health Services. Allergy injections will not be covered under the Network or Non-Network benefit. Covered expenses for allergen extracts will not be covered under the Student Health Services benefit, however, Coverage may be available under the Network or Non-Network benefit.

5. Selected Laboratory Screening Tests, when required for students to participate in academic programs of The Ohio State University.

Note: Many health and fitness screening programs and services are available for students at no or minimal cost thru the Student Wellness Center, Recreation and Physical Activities Center (RPAC), Physical Activities, Student Health Services and the Counseling Consultation Service. Visit the OSU Student Health Insurance Program website for a directory of services.

Counseling and Consultation Service Benefits

Counseling and Consultation Service at The Ohio State University is located on the fourth (4th) floor of the Younkin Success Center at 1640 Neil Avenue. This fully accredited, outpatient facility serves the students of The Ohio State University by providing accessible, high quality, mental health care necessary to maintain an optimal state of health.

Counseling and Consultation Service is a Preferred Network Provider for adult outpatient psychotherapy for students enrolled in the Plan and their covered Dependents age 14 and up. To maximize their available coverage, Insured Students and their covered Dependents should first seek outpatient mental health services from the OSU Counseling and Consultation Service.

Covered Services. Coverage is limited to Medically Necessary services (as determined by Counseling and Consultation Service). Covered Services will not be subject to the Deductible, Coinsurance, or to the Pre-Existing Condition limitations. However, there are applicable Copayments per visit, but for the Insured Student the Copayment is waived for the first ten sessions for each academic year if currently enrolled in classes. For Covered Dependents age 14 and up, the Copayment per visit does apply to each session.

At Counseling and Consultation Service, Insured Students and their covered Dependents age 14 and up may receive individual and group psychotherapy, couples counseling and urgent care during normal hours of operation, which includes limited evening hours. Limited psychiatry services, based on availability, may also be offered to Insured Students and their Covered Dependents with an applicable copayment.

Other Mental Health Coverage. For coverage on child psychotherapy (under age 14) and other psychiatric services, the Insured Student and covered Dependents should utilize OSU Health Plan or the UnitedHealthcare Options PPO Network (outside of Franklin County only) to receive Network Provider benefits. Please refer to the "Student Health Insurance Benefits" section for information.

Student Health Insurance Plan Benefits

Deductible, Coinsurance, and Copayment Rules

The Insured Person's per policy year Deductible applies to all Network and Non-Network Provider Covered Services, unless specified otherwise in this Plan. Any Covered Expense incurred during the last 3 months of the policy year and credited to your per policy year Deductible for that policy year will be applied toward the per policy year Deductible for the next policy year. If the Insured Person is not enrolled for the Summer Quarter, any Covered Expense incurred during the last 3 months will not apply to the per policy year Deductible for the next policy year. If two or more family members are hurt in the same Accident, only one per policy year Deductible needs to be satisfied among them for Covered Expenses relating to the Accident. This special feature applies to Covered Expenses each policy year for the same Accident.

Coinsurance/Copayments

Some Covered Services are subject to Coinsurance and Copayments. This is the amount you must pay to the Doctor or Hospital for each procedure, visit or confinement, each time you receive a Covered Service, including prescription drugs. The Coinsurance is not applied until after you have paid any applicable Deductible that may be required under this Plan. See the Schedule of Benefits for the Copayments. The Coinsurance and Copayments apply toward your Network Provider Out-of-Pocket Maximum.

Covered Services, which are rendered by a Network Provider are subject to a Copayment, but will not be subject to the Deductible.

Out-of-Pocket Maximum

The Out-of-Pocket Maximum applies to Covered Services rendered by a Network Provider or a Non-Network Provider. Once you reach the Out-of-Pocket Maximum shown in the Schedule of Benefits, Covered Expenses will be paid at 100% of Covered Charges for the remainder of the Policy Year or until you reach the Lifetime Maximum Benefit as outlined in the Schedule of Benefits, whichever occurs first. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance, and Copayments. Covered Expenses incurred above Reasonable and Customary Expenses, non-covered services, or penalties for non-precertification do not apply. Any amounts accrued under the Non-Network Out-of-Pocket Maximum will be accrued towards the Network Out-of-Pocket Maximum.

Order of Claims

Regardless of the order claims are incurred, the Deductible and Coinsurance will be applied to Covered Services in the sequence that claims are submitted and payment processed.

Waiver of Emergency Room Copayment

The Emergency Room Copayment will be waived if the Insured Person is admitted to the Hospital immediately following emergency room treatment. The admission must be for the same condition for which the Insured Person received Medical Emergency care; however the applicable coinsurance and deductible will apply.

The PPO Arrangement

The Plan's PPO arrangement is referred to as The OSU Health Plan Provider Network. In or out of Franklin County, students should seek services from an OSU Health Plan Network Provider. Some of the Network Providers included are University Hospital and Children's Hospital, as well as over 500 primary care providers and nearly 3,000 specialists and ancillary providers. Outside of Franklin County, the Plan also affiliates with the UnitedHealthcare Options PPO Network. The most efficient way to get a complete list of all Network Providers is by going to www.osuhealthplan.com.

You should be aware that Network Hospitals may be staffed with Non-Network Providers. Receiving services from a Network Provider at a Non-Network Hospital does not guarantee that all charges will be paid at the Network Provider level of benefits. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits.

It is important to verify that your providers are Network Providers each time you call for an appointment or at the time of service.

Definitions

Whenever used in this Plan:

Accident means a specific unforeseen event, which happens while the Insured Person is covered under this Plan and which directly, and from no other cause results in an Injury.

Coinsurance means the percentage of the Covered Expense for which the Insured Person is responsible for a covered service. The Coinsurance is separate and not a part of the Deductible and Copayment.

Copayment or 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.

Covered Charge or Covered Expense means reasonable charges which are: 1) not in excess of Reasonable and Customary Expenses; 2) not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 3) made for services and supplies not excluded under the policy; 4) made for services and supplies which are a Medical Necessity; 5) made for services included in the Schedule of Benefits; and 6) in excess of the amount stated as a Deductible, if any.

Covered Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

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

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) 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; or (c) a certified nurse midwife while acting within the scope of that certification; other than a member of the person's immediate family. The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

Effective Date means the first date a student or a covered dependent becomes covered under this Plan.

Elective Surgery or Elective Treatment means those health care services or supplies that do not meet the health care needs for a Sickness or Injury. Elective Surgery or Elective Treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

Elective Surgery or Elective Treatment includes, but is not limited to: breast reduction; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities, except for testing; immunizations, except for child hood immunizations; treatment of infertility and routine physical examinations.

Experimental or Investigational Care means a service or supply: (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or (b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished. We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

Hospital means a facility which meets all of these tests: (a) it provides inpatient services for the care and treatment of injured and sick people; and (b) it provides room and board services and nursing services 24 hours a day; and (c) it has established facilities for diagnosis and major surgery; and (d) it is supervised by a Doctor; and (e) it is run as a Hospital under the laws of jurisdiction in which it is located. Hospital does not include a place run mainly: (a) for alcoholics or drug addicts; (b) as a convalescent home; (c) as a nursing or rest home; or (d) as a hospice facility.

Hospital Confinement means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

Injury means bodily injury caused by an Accident which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student and their covered Dependent(s) while insured under this Plan.

Insured Student means a student of The Ohio State University who is eligible and insured for coverage under this Plan.

Lifetime Aggregate Maximum means the amount payable by the Company for incurred Covered Charges for all Injuries or Sicknesses and will never exceed an amount determined by subtracting from the sum of \$500,000 the following: (i) all amounts paid under this policy for all Injuries or Sicknesses; (ii) all amounts paid to or in respect of an Insured for all Injuries or Sicknesses under any other policy issued to the Policyholder by this Company, regardless of the policy period of such other policy.

The Maximum Benefit for all benefit coverage afforded under this policy is \$500,000 for all Injuries or Sicknesses. Covered Charges shall not include amounts paid by the Insured for Coinsurance.

Loss means medical expenses covered by this Plan as a result of Injury or Sickness as defined in this Plan.

Medical Emergency means a medical condition that manifests itself by such acute symptoms of sufficient severity, 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 Insured Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; 2) Serious impairment to bodily functions; 3) Serious dysfunction of any bodily organ or part.

Medical Necessity or Medically Necessary means that a service, drug or supply is needed for the diagnosis or treatment of an Injury or Sickness in accordance with generally accepted standards of medical practice in the United States at the time the service, drug or supply is provided. A service, drug or supply shall be considered "needed" if it: (a) is ordered by a Doctor; and (b) is commonly and customarily recognized through the medical profession as appropriate for the particular Injury or Sickness for which it was ordered. A service, drug or supply shall not be considered as medically necessary if it is investigational, experimental, or educational.

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

Network Providers are Doctors, Hospitals and other healthcare providers who have contracted to provide specific medical care at negotiated prices.

Non-Network Providers have not agreed to any pre-arranged fee schedules.

Out-of-Pocket Maximum means the dollar limit an Insured Person is responsible to pay during a Policy Year, as shown in the Schedule of Benefits. After an Insured Person has reached the Out-of-Pocket Maximum, We cover most benefits at 100% of the Reasonable and Customary Expense for the remainder of the Policy Year. Some benefits, such as prescription coverage however, will always remain payable at the percentage shown in the Schedule of Benefits. The Out-of-Pocket Maximum is met by accumulated Deductible, Coinsurance and Copayments. Amounts above the Reasonable and Customary Expense, non-covered services, or penalties for non-precertification, do not count toward the Out-of-Pocket Maximum.

Policy Year means the 12-month period beginning on the Policy Effective Date of the Plan.

Policyholder means The Ohio State University.

Preferred Allowance means the amount a Network Provider will accept as payment in full for Covered Charges.

Reasonable and Customary Expense means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Reasonable and Customary Expense.

Sickness means sickness or disease which is the sole cause of the Loss under this Policy. Sickness includes both normal pregnancy and complications of pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us and Our means UnitedHealthcare Insurance Company.

You and Your means the Insured Person.

SCHEDULE OF BENEFITS

This schedule includes benefits through Student Health Services, Counseling and Consultation Service, and Health Insurance Benefits with providers in the OSU Health Plan Network Providers, UnitedHealthcare Options PPO Network and Non-Network Providers. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. **Refer to the Covered Service Section for a complete description of benefits.**

PA = Preferred Allowance Max = Maximum
R&CE = Reasonable & Customary Expense

Benefits	Student Health Services	Network Provider	Non-Network Provider
Lifetime Aggregate Maximum Benefit	Not Applicable	\$500,000 ¹ for all Students & Dependents	\$500,000 ¹ for all Students & Dependents
Annual Plan Maximum	\$2,000 ² (\$500 Pharmacy Max)	Not Applicable	Not Applicable
Deductible (per Policy Year) ▪ Individual ▪ Family	Not Applicable	\$100 Per Insured Person, \$300 Per Family	\$500 Per Insured Person, \$1,500 Per Family, (3 per family)
Out-of-Pocket Max (per Policy Year) ▪ Individual (Non-Network Provider accrues towards \$5,000 Network Provider Out-of-Pocket max) ▪ Family (Non-Network Provider accrues towards \$5,000 Network Provider Out-of-Pocket max)	Not Applicable	\$5,000 Per Insured Person \$5,000 Per Insured Person	\$10,000 Per Insured Person \$10,000 Per Insured Person
Inpatient Hospital Expense Benefits ▪ Hospital Room & Board Expense ▪ Misc. Hospital Expense ▪ In Hospital Doctor Visit Expense ▪ Consultant Expense ▪ Routine Newborn Care (See Maternity Expense Benefits) ▪ Skilled Nursing Facility (120 days per Policy Year)	Not Applicable	90% of PA ³ 90% of PA 90% of PA 90% of PA Paid as any other Sickness 90% of PA	60% of R&CE 60% of R&CE 60% of R&CE 60% of R&CE Paid as any other Sickness 60% of R&CE

Benefits	Student Health Services	Network Provider	Non-Network Provider
Surgical Expense Benefits (Inpatient or Outpatient) <ul style="list-style-type: none"> ▪ Surgery Expense ▪ Anesthesia Expense ▪ Assistant Surgeon Expense ▪ Second Surgical Opinion Expense ▪ Multiple Surgical Procedure Expense (see page 23) ▪ Sterilization Expense Benefit 	100% of Billed Charges Outpatient Expense. No coverage for second opinion. Inpatient Surgical Procedures not available.	90% of PA 90% of PA 90% of PA 90% of PA 90% of PA 90% of PA	60% of R&CE 60% of R&CE 60% of R&CE 60% of R&CE 60% of R&CE 60% of R&CE
Voluntary Termination of Pregnancy (Refer page 22)	Not Applicable	90% of PA	60% of R&CE
Doctor's Office Visits Expense Benefit	100% of Billed Charges	100% of PA with \$15 copay per visit ¹⁰	60% of R&CE
Emergency Room Expense Benefits	Not Applicable	100% of PA up to \$500 after a \$100 copayment per visit (waived if admitted) then 90% of PA ¹⁰	100% of R&CE up to \$500 after a \$100 copayment per visit (waived if admitted) then 60% of R&CE
Urgent Care Expense Benefit	Not Applicable	After \$25 copay 100% of PA ¹⁰	60% of R&CE
Physical Therapy/Chiropractic Care Expense Benefits⁴ up to a combined max of \$750 per Policy Year and includes Acupuncture services and Massage therapy.	100% of Billed Charges	90% of PA	60% of R&CE
Eye Exam Expense Benefits, limited to One Exam per Policy Year. Only applies to Comprehensive Plan. Deductible does not apply.	After \$15 copayment, paid in full ⁵ . Also applies to OSU College of Optometry. Glass frames and lenses discounted by 20%. Contact lenses fittings only discounted by 15%	After \$15 copayment, 100% of Actual Expense up to a max of \$50 per Policy Year ¹⁰	After \$15 copayment, 100% Actual Expense up to a max of \$50 per Policy Year

Benefits	Student Health Services	Network Provider	Non-Network Provider
Outpatient Expense Benefits			
▪ Hospital Outpatient Department Expense	100% of Billed Charges	90% of PA	60% of R&CE
▪ Diagnostic X-ray and Laboratory Expense (includes testing to determine pre-disposition of disease indicated by family history. Pre-determination required.)	100% of Billed Charges	90% of PA	60% of R&CE
▪ Occupational Therapy	Not Applicable	90% of PA	60% of R&CE
▪ Allergy Testing and Allergy Extracts Expense	100% of Billed Charges	90% of PA	60% of R&CE
▪ Allergy Injections Expense	50% of Billed Charges	Not Covered	Not Covered
▪ Treatment for Transgender Medical Condition	Paid as any other Sickness	Paid as any other Sickness	Paid as any other Sickness
▪ Consultant Expense	100% of Billed Charges	100% of PA with \$15 copay per visit ¹⁰	60% of R&CE
Pre-admission Tests Expense Benefit	100% of Billed Charges	90% of PA	60% of R&CE
Maternity Expense Benefits	Not Applicable	Paid as any other Sickness	Paid as any other Sickness
Eating Disorder , includes both medical and behavioral services which are Medically Necessary	100% of Billed Charges	90% of PA	60% of R&CE
Dental Expense Benefit , benefits paid on Injury to Sound, Natural Teeth only	100% of Billed Charges	90% of PA see page 25	60% of R&CE see page 25
Home Health Care , includes home infusion therapy (limited to 40 home visits per Injury / Illness).	Not Applicable	90% of PA	60% of R&CE

Benefits	Student Health Services	Network Provider	Non-Network Provider
Preventive Screenings			
<ul style="list-style-type: none"> ▪ Immunization Expense 	50% of Billed Charges up to \$300	Not Covered (except under Child Health Supervision Benefit)	Not Covered (except under Child Health Supervision Benefit)
<ul style="list-style-type: none"> ▪ Annual Sexual Health Screening includes: syphilis, chlamydia, HIV and other tests based on patient history. 	100% of Billed Charges	Not Covered	Not Covered
<ul style="list-style-type: none"> ▪ Child Health Supervision Services Benefit (Ages 10 to 18 - \$250 maximum per Policy Year) 	Not Applicable	90% of PA see page 25	60% of R&CE see page 25
<ul style="list-style-type: none"> ▪ Mammography Examination Expense Benefit 	Not Applicable	90% of PA see page 26 ¹⁰	60% of R&CE see page 26
<ul style="list-style-type: none"> ▪ Pap Smear Examination Expense Benefit (Covered once per Policy Year) 	100% of Billed Charges	100% of PA ¹⁰	60% of R&CE
<ul style="list-style-type: none"> ▪ Prostate Cancer Screening Expense Benefit 	Not Applicable	90% of PA ¹⁰	60% of R&CE
<ul style="list-style-type: none"> ▪ Colorectal Health Screening Benefit (Annual screening for Insureds over 50 years of age only) 	Not Applicable	90% of PA ¹⁰	60% of R&CE
Reconstructive Breast Surgery Expense Benefits	Not Applicable	90% of PA	60% of R&CE
Cancer Clinical Trials Expense Benefit	Not Applicable	Paid as any other Sickness	Paid as any other Sickness
Diabetes Treatment Expense Benefit	100% of Billed Charges. Prescription covered under Prescription benefit	90% of PA	60% of R&CE
Prosthetic and Orthotic Device Expense Benefit	100% of Billed Charges when in regular stock	90% of PA	90% of R&CE
Ambulance Expense Benefit \$1,000 max (Per Policy Year)	Not Applicable	90% of R&CE/	90% of R&CE/

Benefits	Student Health Services	Network Provider	Non-Network Provider
Durable Medical Equipment Expense Benefit	100% of Billed Charges when in regular stock	90% of R&CE	90% of R&CE
Prescription Drug Expense Benefit (34 day supply per fill)	10% Coinsurance for Generic or 20% Coinsurance for Brand with no generic equivalent, 50% copayment for Brand with a generic equivalent; up to a max. benefit of \$500 per Policy Year. \$10 min. copayment per prescription.	10% Coinsurance for Generic or 20% Coinsurance for Brand with no generic equivalent, 50% copayment for Brand with a generic equivalent; up to a max. benefit of \$1,250 ⁶ per Policy Year. \$10 min. copayment per prescription.	10% Coinsurance for Generic or 20% Coinsurance for Brand with no generic equivalent, 50% copayment for Brand with a generic equivalent; up to a max. benefit of \$1,250 ⁶ per Policy Year. \$10 min. copayment per prescription.
Learning Disabilities and ADHD Expense Benefit, limited to testing only , up to a combined maximum of \$250 Per Policy Year. For treatment, please refer to footnote #7.	Not Applicable	50% of PA	50% of R&CE
Biologically Based Mental Illness , please refer to page 27.	Paid as any other Sickness	Paid as any other Sickness ¹⁰	Paid as any other Sickness
Mental & Nervous Condition Expense Benefit			
<ul style="list-style-type: none"> ▪ Inpatient, up to a combined maximum of 30 days Per Policy Year. ▪ Outpatient⁷ <ul style="list-style-type: none"> ▪ Adult Psychotherapy (age 14 and up) ▪ Child Psychotherapy ▪ Psychiatric Services (age 14 and up) 	<ul style="list-style-type: none"> Not Applicable 100% of Billed Charges after \$15 Copayment⁸ Not Applicable 100% of Billed Charges after \$15 Copayment 	<ul style="list-style-type: none"> 90% of PA 60% of PA 90% of PA 90% of PA 	<ul style="list-style-type: none"> 60% of R&CE 60% of R&CE 60% of R&CE 60% of R&CE

Benefits	Student Health Services	Network Provider	Non-Network Provider
Alcohol and Drug Abuse Condition Expense Benefit			
▪ Inpatient	Not Applicable	90% of PA	60% of R&CE
▪ Outpatient ⁹			
▪ Adult Psychotherapy (age 14 and up)	100% of Billed Charges after \$15 Copayment	70% of PA	60% of R&CE
▪ Child Psychotherapy	Not Applicable	90% of PA	60% of R&CE
▪ Psychiatric Services (age 14 and up)	100% of Billed Charges after \$15 Copayment	90% of PA	60% of R&CE

1. This is combined Network Provider and Non-Network Provider Benefit maximum per Insured Person
2. Expense in excess of the \$2,000 medical and \$500 prescription Annual max may be eligible for benefits at the Network Provider level.
3. PA means the negotiated amount a Network Provider will accept as payment for covered medical expense. Insured Person's Coinsurance is based on the Network fee schedule.
4. There is a \$750 combined (Physical and Chiropractic Care) Network and Non-Network Benefit max Per Policy Year. Benefits also can be provided through a licensed Athletic Trainer for approved physical/medical and rehabilitative services.
5. Glass frames and lenses and contact lenses fittings only available at Student Health Services or OSU College of Optometry.
6. The combined max. benefit outside of the Student Health Center for outpatient prescription drugs is \$1,250 per policy year.
7. The benefits are limited to a combined max. of 25 visits per Policy Year outside of Counseling and Consultation Service. Services must be Pre-Certified after the fourth visit for mental health services. Includes treatment of learning disabilities/ADHD.
8. The Copayment for OSU students enrolled in classes is waived for the first 10 visits for Psychotherapy.
9. Benefits are limited to a combined max. of \$2,000 per Policy Year outside of Counseling and Consultation Service. Services must be Pre-Certified after the fourth visit.
10. Network Deductible does not apply.

Covered Services

Your health care services under this Plan are listed below. In order for these services and supplies to be considered Covered Services, they must be:

1. Authorized by a Doctor;
2. Rendered and billed by a Doctor or Provider; and
3. Medically Necessary, except as specified.

Except for the following services, this Plan will provide coverage for services subject to the Pre-Existing Condition Limitations, rendered and billed by the Wilce Student Health Center once the Insured Student has exhausted the annual maximum benefit, or the prescription drug maximum benefit, under the Student Health Services portion of the Plan:

1. Preventive medical services.
2. Allergy injections.
3. Nutritional services.

Refer to the section describing your Student Health Services benefits on page 10 for more detail.

Please be advised that some services are subject to Pre-Certification Approval. Refer to the section on Utilization Review Management on page 31 for details.

Inpatient Hospital Expense Benefits: The following inpatient Hospital services are covered:

- **Hospital Room and Board Expense Benefit:** We will pay the Covered Percentage of the Covered Charges incurred, as shown in the Schedule of Benefits, for a semi-private room containing two or more beds, including meals, special diets and nursing services, other than private duty nursing services. Coverage includes a bed in a special care unit.
- **Miscellaneous Hospital Expense Benefit:** We will pay the Covered Percentage of the Covered Charges incurred, as shown in the Schedule of Benefits for the following Miscellaneous Hospital Expenses:
 - (a) anesthesia, anesthesia supplies and services;
 - (b) operating, delivery and treatment rooms and equipment;
 - (c) diagnostic x-ray and laboratory tests;
 - (d) oxygen tent;
 - (e) blood and blood services;
 - (f) prescribed drugs and medicines (excluding take home drugs);
 - (g) medical and surgical dressings, supplies, casts and splints;
 - (h) radiation therapy, intravenous chemotherapy, kidney dialysis, and inhalation therapy;
 - (i) physical and occupational therapy; and
 - (j) other necessary and prescribed Hospital expenses.
- **In Hospital Doctor's Fees and Medical Expense Benefit:** When, by reason of Injury or Sickness, an Insured Person who is confined as a resident bed-patient in a Hospital, requires the services of a Doctor, who may or may not have performed the surgery on the Insured Person, We will pay the Covered Percentage of the Covered Charge incurred for such services, as shown in the Schedule of Benefits. The following medical services performed by a Doctor are covered on an inpatient basis: (a) limited to one Doctor visit per day (b) constant care and treatment while an Insured Person is confined in an intensive care unit; (c) care by two or more Doctors during one Hospital stay when the Insured Person's condition requires the skill of separate Doctors; (d) consultation by another Doctor when requested by the Insured Person's Doctor. Coverage is limited to one consultation per admission. Staff consultations required by Hospital rules are not covered.

- **Consultant Expense Benefit:** If, by reason of Injury or Sickness, an Insured Person requires the service of a Consultant or a Specialist when they are deemed necessary and ordered by an attending Doctor for the purpose of confirming and determining a diagnosis, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits. Limited to one consultation per admission.

Surgical Expense Benefits: The following Surgical Services performed by a Doctor are covered on an inpatient or outpatient basis.

- **Surgery Expense Benefit:** When, by reason of Injury or Sickness, an Insured Person requires surgery on an inpatient or outpatient basis, We will pay the Covered Percentage of the Covered Charges incurred, as shown in the Schedule of Benefits, for the Surgical Expense, in connection with any one surgical procedure. Surgical Expense means charges by a Doctor for: (a) a surgical procedure; (b) necessary preoperative treatment during a Hospital stay in connection with such procedure; and (c) usual post-operative treatment.
- **Multiple Surgical Procedures Expense Benefit:** When an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple surgical procedures performed during the same operative session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive surgical procedure then being performed, and with regard to the less expensive surgical procedure in an amount equal to 50 percent of the Covered Percentage of the Covered Charge for these procedures.
- **Anesthesia Expense Benefit:** If, in connection with such operation, the Insured Person requires the services of an anesthetist, We will pay the Expenses incurred; but We will not pay more than the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits.
- **Assistant Surgeon Expense Benefit:** If, in connection with such operation, the Insured Person requires the services of an Assistant Surgeon, We will pay the Expense incurred; but We will not pay more than the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits.
- **Second Surgical Opinion Expense Benefit:** This Plan shall provide benefits to an Insured Person for a second opinion consultation by a board certified specialist on the need for non-emergency surgery which has been recommended by the Insured Person's Doctor. The Specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will also be provided for any required x-rays and diagnostic tests done in connection with that consultation. We will pay the Covered Charges incurred by the Insured Person as shown in the Schedule of Benefits. Any Deductible is waived for Expenses incurred in connection with the Second Surgical Opinion.

Voluntary Termination of Pregnancy Expense Benefit: If, as a result of pregnancy, an Insured Person has a voluntary termination of pregnancy, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits. Covered Expenses for the voluntary termination of pregnancy must be incurred while this Plan is in force as to the Insured Person. Due to Ohio state law, this benefit is not available to Graduate Associates or Fellows who are receiving the University subsidy for the Student Health Insurance Plan.

Outpatient Expense Benefit: If, by reason of Injury or Sickness, an Insured Person incurs expenses in a Doctor's office, Hospital outpatient department, emergency room, clinical lab, radiological facility, or other similar facility licensed by the state, We will pay the Covered Percentage of the Covered Charges incurred for Outpatient Services as shown in the Schedule of Benefits.

Covered Charges for Outpatient Services are charges for the following services:

- (a) a Doctor's office visit, while not Hospital Confined and limited to 1 per day;
- (b) a Hospital outpatient department or emergency room;
- (c) diagnostic x-ray and laboratory testing;
- (d) allergy testing and allergy extracts;
- (e) blood and blood services, if provided and billed by a Hospital or other facility;
- (f) physical and occupational therapy, including acupuncture and massage therapy, and chiropractic care, limited to 1 visit per day;
- (g) radiation therapy, intravenous chemotherapy, kidney dialysis, inhalation therapy, biofeedback;
- (h) radiological lab or other similar facility licensed by the state;
- (i) annual eye exam benefit;
- (j) home health care, including home infusion therapy; or
- (k) medically necessary non-surgical treatment for transgender medical treatment, limited to office visits, lab tests, pharmacy and hormone treatment.

Pre-Admission Tests Expense Benefit: This Plan shall provide for reimbursement of charges made by a Hospital for use of its outpatient facilities for tests ordered by a Doctor. The tests must be performed as a planned preliminary to the Insured Person's admission as an inpatient for surgery in that same Hospital. However: (a) the test must be necessary for, and consistent with, the diagnosis and treatment of the condition for which surgery is to be performed; (b) reservations for a Hospital bed and for an operating room must be made prior to the date the tests are done; (c) the surgery actually takes place within seven days of pre-surgical tests; and (d) the Insured Person is physically present at the Hospital for the tests. We will pay the Covered Percentage of the Covered Charges as shown in the Schedule of Benefits.

Maternity Expense Benefit: Benefits will be paid as specified in the Schedule of Benefits for a minimum of forty-eight hours of inpatient care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient care following a cesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The policy shall cover a physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals. The coverage shall apply to services provided in a medical setting or through home health care visits. The coverage shall apply to a home health care visit only if the health care professional who conducts the visit is knowledgeable and experienced in maternity and newborn care. When a decision is made to discharge a mother or newborn prior to the expiration of the applicable number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to all follow-up care that is provided within seventy-two hours after discharge. When a mother or newborn receives at least the number of hours of inpatient care required to be covered, the coverage of follow-up care shall apply to follow-up care that is determined to be medically necessary by the health care professionals responsible for discharging the mother or newborn. Any decision to shorten the length of inpatient stay shall be made by the physician attending the mother or newborn, except that if a nurse-midwife is attending the mother in collaboration with a physician, the decision may be made by the nurse/midwife. Decisions regarding early discharge shall be made only after conferring with the mother or a person responsible for the mother or newborn. For the purposes of this benefit, a person responsible for the mother or newborn may include a parent, guardian, or any other person with authority to make medical decisions for the mother or newborn.

Child Health Supervision Services Benefit: Benefits shall be provided as specified on the Schedule of Benefits for an Insured for child health supervision services from the moment of birth until age nine. Benefits for child health supervision services that are provided to a child during the period from birth to age one shall include benefits for the hearing screening for newborns or infants required by Ohio law. Covered Charges shall include those for: (a) all visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control; (b) services performed at birth, two months, four months, six months, nine months, twelve months, fifteen months, eighteen months, two years and annually thereafter until age nine; (c) all visits for and costs of age-appropriate screening tests for tuberculosis, anemia, Lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics; (d) a medical history, physical examination, developmental assessment, and parental anticipatory guidance services at each of the visits required under terms (a), (b), and (c) above; and (e) any laboratory tests considered necessary by the Doctor as indicated by the services provided under items (a), (b), (c), or (d) above. Coverage must be consistent with: (a) public policy; (b) professional standards; and (c) scientific evidence of the effectiveness.

Mammography Benefit: Benefits shall be provided as specified on the Schedule of Benefits for an Insured for a screening mammography to detect the presence of breast cancer. Screening mammography does not include diagnostic mammography. The maximum benefit payable for screening mammographies is 130% of the Medicare reimbursement amount. Benefits shall cover expenses in accordance with all of the following:

- (1) If an Insured is at least 35 years of age but under 40 years of age, one screening mammography;
- (2) If an Insured is 40 through 49 years of age inclusive, one screening mammography every other year, or more frequently upon recommendation of a Doctor;
- (3) If an Insured is at least 50 years of age but less than 65 years of age, one screening mammography every year;
- (4) If a licensed Doctor has determined that the Insured has risk factors to breast cancer, one screening every year.

Benefits shall be provided only for screening mammographies that are performed in a facility or mobile mammography screening unit that is accredited under the American College of Radiology mammography accreditation program or in a hospital.

Screening mammography means a radiological examination utilized to detect unsuspected breast cancer at an early stage in asymptomatic people and includes the x-ray examination of the breasts using equipment that is dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, film, and cassettes, and that has an average radiation exposure delivery of less than one rad mid-breast. Screening mammography includes 2 views of each breast. The term also includes the professional interpretation of the film. Insured is responsible only for deductible and copayment amounts.

Reconstructive Breast Surgery Expense Benefit: We cover charges following a mastectomy for the following services (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the nondiseased breast to produce a symmetrical appearance; and (c) prostheses and treatment of physical complications for all stages of mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes). We will pay the Covered Percentages of the Covered Charges incurred as shown in the Schedule of Benefits.

Pap Smear Examination Expense Benefit: We cover charges for Covered Expenses incurred, as shown in the Schedule of Benefits, for a Cytologic Screening (pap smear). Benefits will be paid for a Cytologic Screening once a year, or more frequently if recommended by a Doctor. Such benefits will include the examination, laboratory fee, and the Doctor's interpretation of the laboratory results. We will pay the Covered Percentages of the Covered Charges incurred as shown in the Schedule of Benefits.

Prostate Cancer Screening Expense Benefit: We will pay the Covered Percentage of the Covered Charges incurred, as shown in the Schedule of Benefits, for Prostate Cancer Screening for: (a) men age 40 and over who are symptomatic or in a high risk category; or (b) an annual screening for men age 50 and over. The Prostate Cancer Screening must consist at a minimum of a Prostate Specific Antigen (PSA) blood test and a digital rectal examination. We will pay the Covered Percentages of the Covered Charges incurred as shown in the Schedule of Benefits.

Accidental Dental Expense Benefit: When an Insured Person incurs expenses for dental treatment for Injury to sound natural teeth, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits.

Benefits for Cancer Clinical Trials: Benefits will be paid the same as any other Sickness for Routine Patient Care administered to an Insured participating in any stage of an Eligible Cancer Clinical Trial, if those expenses would be paid if the Insured was not participating in a clinical trial.

“Eligible Cancer Clinical Trial” means a cancer clinical trial that meets all of the following criteria:

- a) A purpose of the trial is to test whether the intervention potentially improves the trial participant's health outcomes.
- b) The treatment provided as part of the trial is given with the intention of improving the trial participant's health outcomes.
- c) The trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology.
- d) The trial does one of the following: i) Tests how to administer a health care service, item, or drug for the treatment of cancer; ii) Tests responses to a health care service, item or drug for the treatment of cancer; iii) Compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items or drugs for the treatment of cancer; iv) Studies new uses of a health care service, item, or drug for the treatment of cancer.
- e) The trial is approved by one of the following entities: i) The National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services; ii) The United States Department of Defense; iii) The United States Department of Veterans' Affairs.

“Routine Patient Care” means all health care services consistent with the coverage provided in the policy for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a Cancer Clinical Trial, and that was not necessitated solely because of the trial.

Benefits will not be paid for:

- a) A health care service, item, or drug that is the subject of the cancer clinical trial;
- b) A health care service, item, or drug provided solely to satisfy data collection and analysis needs for the cancer clinical trial that is not used in the direct clinical management of the patient;
- c) An investigational or experimental drug or device that has not been approved for market by the United States Food and Drug Administration;
- d) Transportation, lodging, food, or other expenses for the Insured, or a family member of companion of the Insured, that are associated with the travel to or from a facility providing the cancer clinical trial;
- e) An item or drug provided by the cancer clinical trial sponsors free of charge for any patient;
- f) A service, item, or drug that is eligible for reimbursement by a person other than the insurer, including the sponsors of the cancer clinical trial.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Benefits for Biologically Based Mental Illness: Benefits will be paid the same as any other Sickness for the treatment of Biologically Based Mental Illness if both of the following apply:

- 1) The Biologically Based Mental Illness is clinically diagnosed by a Doctor authorized to practice medicine and surgery or osteopathic medicine and surgery, a psychologist, a professional clinical counselor, professional counselor, independent social worker, or a clinical nurse specialist whose nursing specialty is mental health.
- 2) The prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

“Biologically Based Mental Illness” means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the diagnostic and statistical manual of mental disorders published by the American Psychiatric Association.

Benefits shall be subject to all Deductible, copayment, coinsurance, limitations, or any other provisions of the policy.

Mental and Nervous Condition & Alcohol and Drug Abuse Condition Expense Benefit:

If an Insured Person requires treatment for a Mental or Nervous Condition or on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

Benefits for Inpatient Hospital Confinement

- (a) When the Insured Person requires Hospital confinement for treatment of a Mental or Nervous Condition, We will pay the Covered Percentages of the Covered Charges for such Hospital confinement incurred as shown in the Schedule of Benefits.
- (b) When the Insured Person is confined as an inpatient in: i) a Hospital; or ii) a Detoxification Facility for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency, We will pay the Covered Percentage of the Covered Charges for such Hospital Confinement incurred as shown in the Schedule of Benefits.

Such confinement must be in a licensed or certified facility, including Hospitals.

Benefits for Outpatient Services

- (a) We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of Mental and Nervous Conditions. The Mental and Nervous Condition must, in the professional judgment of health care providers, be treatable and the treatment must be Medically Necessary. Outpatient treatment and Doctor services include charges made by an outpatient treatment department of a Hospital or community mental health facility, or charges for services rendered in a Doctor's office. Treatment may be provided by any properly licensed Doctor, psychologist or other provider as required by law.
- (b) We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits for covered outpatient services for the treatment of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency. Outpatient treatment and Doctor services include charges for services rendered in a Doctor's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by, or under the clinical supervision of, a licensed Doctor or a licensed psychologist who certifies every three months that the Insured Person needs to continue such treatment.

Covered Charges for Outpatient Mental & Nervous Condition Expenses are limited to a combined maximum of 25 visits per policy year outside of Counseling and Consultation Service and the copayment for the first 10 visits at the Counseling and Consultation Service is only waived for OSU students currently enrolled in classes. Covered Charges for Outpatient Alcohol and Drug Abuse Condition Expense are limited to a combined maximum of \$2,000 per Policy Year outside of Counseling and Consultation Service. Services must be Pre-Certified after the 4th visit for either Outpatient Mental & Nervous Conditions or Outpatient Alcohol and Drug Abuse Condition Expense.

Definitions

Mental or Nervous Conditions means those conditions listed in the standard nomenclature of the American Psychiatric Association.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition which is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely intoxicated individual to fulfill the physical, social and emotional needs of the individual by: (a) monitoring the amount of alcohol and other toxic agents in the body of the individual; (b) managing withdrawal symptoms; and (c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol or Drug Abuse.

Diabetes Treatment Expense Benefit: We cover charges for Medically Necessary diabetes equipment, diabetes supplies, and diabetes outpatient self-management training and educational services, including medical nutrition therapy, that the Insured Person's treating Doctor or other appropriately licensed health care provider or a Doctor who specializes in the treatment of diabetes, certifies are necessary for the treatment of: (a) insulin-using diabetes; (b) non-insulin-using diabetes; or (c) elevated blood glucose levels induced by pregnancy. The diabetes outpatient self-management training and educational services, including medical nutrition therapy shall be provided through programs supervised by an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management. We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits.

Ambulance Expense Benefit: When, by reason of Injury or Sickness, an Insured Person requires the use of a community or Hospital ambulance in a Medical Emergency, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Benefits. Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, scene of accident or Medical Emergency to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered services appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury or Sickness. Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

Prosthetic and Orthotic Device and Durable Medical Equipment Benefit: If, by reason of Injury or Sickness, an Insured Person requires the use of a Prosthetic or Orthotic Device, or Durable Medical Equipment, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such devices and equipment as shown on the Schedule of Benefits and, 1) when prescribed by a Physician, and 2) a written prescription accompanies the claim submitted. Durable medical equipment includes equipment that is: 1) primarily and customarily used to serve a medical purpose; 2) can withstand repeated use; and 3) generally is not useful to a person in the absence of Injury or Sickness. No benefits will be paid for rental charges in excess of purchase price. Replacement Durable Medical Equipment is not covered.

Prescription Drug Expense Benefit: If by reason of Injury or Sickness, an Insured Person requires prescription drugs, We will pay the Covered Percentage of the Covered Charges incurred by the Insured Person for such drugs, subject to the Coinsurance, as shown in the Schedule of Benefits. The maximum Pharmacy benefit is \$1,250 per policy year for Insured Persons (in addition to the \$500 available to insured students at the Student Health Center). Covered prescriptions are subject to a 10% generic coinsurance or a 20% brand coinsurance with no generic equivalent or a 50% brand coinsurance with generic equivalent. There is a minimum \$10 coinsurance per prescription. Non-student dependents covered by an Insured Student will have access to Outpatient Prescription Drugs and coverage through the Student Health Services Pharmacy. Covered dependents can fill/refill their prescriptions subject to the 10% generic coinsurance, 20% brand coinsurance with no generic equivalent, or a 50% brand coinsurance with generic equivalent. There is a \$10 minimum coinsurance up to \$1,250 per policy year.

The prescription drugs must be prescribed by a Doctor. We only cover prescription drugs which are approved for the treatment of the Insured Person's Injury or Sickness by the Food and Drug Administration. We will also cover a drug prescribed for a treatment for which it has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which the drug has been prescribed in one of the following established reference compendia: a) the American Medical Association Drug Evaluations; (b) the American Hospital Formulary Service Drug Information; (c) the United States Pharmacopoeia Drug Information; or (d) it is recommended by a clinical study or review article in a major peer-reviewed professional journal. However, Covered Charges do not include Experimental or Investigational Drugs or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed.

Scholastic Emergency Services: Global Emergency Medical Assistance

If you are a student insured with this insurance plan, you and your insured spouse or Domestic Partner and minor child(ren) are eligible for Scholastic Emergency Services (SES). The requirements to receive these services are as follows:

International Students, insured spouse or Domestic Partner and insured minor child(ren): You are eligible to receive SES worldwide, except in your home country.

Domestic Students, insured spouse or Domestic Partner and insured minor child(ren): You are eligible for SES when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

SES includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All SES services must be arranged and provided by SES, Inc.; any services not arranged by SES, Inc. will not be considered for payment.

Key Services include:

- * Medical Consultation, Evaluation and Referrals
- * Foreign Hospital Admission Guarantee
- * Emergency Medical Evacuation
- * Medically Supervised Repatriation
- * Emergency Counseling Services
- * Lost Luggage or Document Assistance
- * Care for Minor Children Left Unattended Due to a Medical Incident
- * Prescription Assistance
- * Critical Care Monitoring
- * Return of Mortal Remains
- * Transportation to Join Patient
- * Interpreter and Legal Referrals

Please go to www.Gallagherkoster.com for additional information on SES Global Emergency Assistance Services, including service descriptions and program exclusions and limitations.

To access services please call:

(877) 488-9833 Toll-free within the United States

(609) 452-8570 Collect outside the United States

Services are also accessible via e-mail at medservices@assistamerica.com.

When calling the SES Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and Reference Number;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached

SES is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by SES, Inc. Claims for reimbursement of services not provided by SES will not be accepted. Please refer to your SES brochure or Program Guide at www.uhcsr.com for additional information, including limitations and exclusions pertaining to the SES program.

Utilization Review Management

The Plan contracts with CareAllies to provide utilization management services. The goal of the program is to assure medical necessity appropriateness of setting and length of treatment for all proposed level of care. The review also monitors an Insured Person's treatment progress and identifies when case management intervention is needed. Once an Insured Person contacts CareAllies, a notice of Pre-Certification and the approved treatment plan are transferred to the Claims Administrator. Pre-Certification does not guarantee benefits.

Pre-Certification Requirements

Pre-Certification of Hospital Admissions. Pre-Admission Certification must be obtained for every Hospital Admission. Please refer to the subsequent sections on Pre-Admission Certification provisions for Maternity and Medical Emergency admissions. These admissions have separate certification requirements.

Insured Persons are responsible for obtaining Pre-Admission Certification and are responsible for informing the Hospital or other Doctor that their insurance plan requires Pre-Admission Certification.

To obtain Pre-Admission Certification:

- CareAllies must be provided with necessary information to make decisions regarding the Medical Necessity of admission; and
- CareAllies must be contacted no less than forty-eight (48) hours prior to Hospital admissions. This does not apply to Medical Emergency admissions. Refer to the following section for descriptions of the certification provisions for this type of admission. Notice may be given to CareAllies by the Hospital, admitting Doctors, Insured Person, or family members of Insured Person.

Notice may be given by calling CareAllies at 1-800-348-1313.

The following information is requested by CareAllies in order to evaluate planned Hospital admissions:

- Name, social security number, and age of patient;
- Student's name, social security number, and name of the university;
- Scheduled dates of admissions; and
- Names and telephone numbers of admitting Doctors and Hospitals.

When Pre-Admission Certification is provided to Insured Persons, a certain number of Inpatient Hospital days for the stays are assigned. If CareAllies is not informed of admissions within the required period of time, payment of benefits for admitting Doctors and Hospitals charges are reduced by 50% of Covered Expenses up to \$5,000. This is referred to as a "penalty". This penalty will not be applied toward any Deductibles, Coinsurance or Out-of-Pocket Maximum. It is not necessary to pre-certify Hospital admissions that occur outside of the United States.

Pre-Certification of Medical Emergency Admissions. If an Insured Person is admitted to a Hospital for Medical Emergency admission, notice of admission must be provided to CareAllies no later than one (1) day following the date of admission. Notice may be given to CareAllies by the Hospital, admitting Doctor, Insured Person, or family members of Insured Person.

Notice may be given by calling CareAllies at 1-800-348-1313.

CareAllies reviews cases within one (1) working day of the date they are informed of the admission. The reviews are performed with Insured Persons' Doctors or designated staff to determine if continued Hospital stays are Medically Necessary. If CareAllies is not informed of Medical Emergencies within the required period of time, payment of benefits for admitting Doctors and Hospitals charges are reduced by 50% of Covered Expenses up to \$5,000. This is referred to as a "penalty". This penalty will not be applied toward any Deductibles, Coinsurance or the Out-of-Pocket Maximum.

Medical Emergency admissions are defined as admissions to a Hospital through the emergency rooms of those facilities for treatment of a Medical Emergency. Medical Emergency admissions are unplanned admissions scheduled less than forty-eight (48) hours prior to the admission, for treatment of a Medical Emergency. It is not necessary to pre-certify Hospital admissions that occur outside the United States.

Pre-Certification of Maternity Admissions. An anticipated maternity admission must be reported to CareAllies during the first three (3) months of the pregnancy to ensure that a high risk screening evaluation will be done. When an Insured Person is actually admitted to a Hospital for the express purpose of giving birth, CareAllies should be notified of the admission no later than one (1) day following the admission date. Notice may be given to CareAllies by the Hospital, admitting Doctor, Insured Person, or family members of the Insured Person.

Notice may be given by calling CareAllies at 1-800-348-1313.

If the admission and discharge dates are the same or if the Insured Person is discharged on the day following the admission date, it is not necessary to notify CareAllies of the maternity admission following the admission date.

Maternity admissions are admissions to Hospitals expressly for giving birth.

Additional Hospitalization Reviews. Additional Hospitalization reviews include:

- During an Insured Person's Hospital stay, CareAllies continues to review the Hospital stay. This does not apply to maternity admissions except if the stay is greater than two days. The purpose of continued reviews is to obtain updates as to an Insured Person's progress and, if necessary, to enable CareAllies to reevaluate the Medical Necessity of a continued Hospital stay.
- All weekend (Friday and Saturday) Hospital admissions are reviewed. Coverage is limited to Medically Necessary admissions.
- Review for discharge planning is also conducted. Discharge planning identifies patients who require extended care following a discharge. Discharge planning also determines the most appropriate setting for continued care.

Pre-Certification for Home Infusion Therapy. Pre-certification must be obtained for any Home Infusion Therapy services. Insured Persons are responsible for obtaining Pre-Certification and are responsible for informing their Doctor that their insurance plan requires Pre-Certification.

To obtain Pre-Certification for Home Infusion Therapy:

- CareAllies must be provided with necessary information to make decisions regarding the Medical Necessity of Home Infusion Therapy services; and
- CareAllies must be contacted no less than forty-eight (48) hours prior to the receipt of these services.

Notice may be given by calling CareAllies at 1-800-348-1313.

Pre-Certification for Outpatient Mental Health and Nervous Condition and Alcohol and Drug Abuse Condition Benefits. Pre-Certification must be obtained in order to receive the maximum benefit payable for Outpatient Mental Health and Nervous Condition and Alcohol and Drug Abuse Condition Benefits. A Pre-Certification is a pre-treatment review by CareAllies of the Medical Necessity of Outpatient Mental Health and Nervous Condition and Alcohol and Drug Abuse Condition Benefits Services. Pre-Certification must be obtained after the fourth outpatient visit for a mental illness, counseling, or substance abuse condition (alcoholism and drug addiction). Pre-Certification may be obtained by calling CareAllies at 1-800-338-9059.

It is the Insured Person's responsibility to obtain Pre-Certification and inform the Doctor that they are a participant in a program that has Pre-Certification requirements. Pre-Certification does not guarantee benefits.

To obtain Pre-Certification:

1. CareAllies must be provided with information necessary to make a decision as to the Medical Necessity of the admission; and
2. CareAllies must be informed no later than three days prior to the fifth visit. Notice can be given by: (a) the Hospital; (b) the Doctor; or (c) the Insured Person.

When Pre-Certification is provided to the Insured Person, a certain length of treatment for the service will be assigned. During the treatment a continued treatment review will be conducted and extensions to the initial treatment plan will be viewed for Medical Necessity. If services are not determined to be Medically Necessary during pretreatment review or continued treatment review, the Insured Person and the Doctor will be notified and no payment will be made for services determined to be not Medically Necessary.

If pretreatment or continued treatment review is not obtained, a retrospective review of services will be completed prior to payment. If, after retrospective review, it is determined that services were not Medically Necessary, payment of benefits for Doctors and Hospitals charges will be reduced by 50% of Covered Expenses up to \$5,000. This is referred to as a "penalty". This penalty will not be applied toward any Deductible, Coinsurance or Out-of-Pocket Maximum.

If the retrospective review reveals that the services were not Medically Necessary, the Insured Person and the Doctor will be notified and no payment will be made for those services determined to be not Medically Necessary.

Individual Benefit Management. Individual Benefit Management is a voluntary program. It is designed to inform patients of more cost-effective settings for treatment. On an exception basis, and subject to the approval of CareAllies, benefits may be provided for settings and/or procedures not expressly provided for, but not prohibited by law, rule or policy. All requests for managed care are individually reviewed by CareAllies. If approved, CareAllies notifies the Claims Administrator.

CareAllies has the right to deny an extension of benefits under the Individual Benefit Management provision. CareAllies also has the right to make recommendations based on medical need pursuant to the terms of the Plan, exclusive of this provision. In each instance, actual application of this managed care benefit must be approved by Insured Persons.

Exclusions and Limitations

Pre-Existing Conditions Limitation

A Pre-existing Condition is any Sickness, Injury, or related condition for which the Insured Person received medical treatment (including prescription drugs) or advice, or which was diagnosed by a Doctor or other Health Care Provider during the 90 (ninety) day period immediately preceding the Effective Date of the Insured Person's coverage.

The Pre-existing Condition Waiting Period is 90 (ninety) consecutive days. Coverage will not be provided for a Pre-existing Condition until the waiting period has elapsed. The Pre-existing Condition Waiting Period applies to all persons covered under the Plan and begins on the Insured Person's Effective Date.

If an Insured Person receives treatment or service for a Pre-Existing Condition: (a) We will not pay benefits for such condition until the day after a 90 (ninety) consecutive day period has passed from the Insured Person's effective date, and (b) We will pay only for loss or Covered Expense incurred after such 90 (ninety) consecutive day period.

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

The Pre-existing Condition Waiting Period will not apply if you meet the following criteria:

1. a) you elected and exhausted any continuation coverage available under COBRA or a similar state program, that was available to you before enrolling under this Plan. This specific criteria does not apply if you were not eligible for continuation coverage under COBRA or a similar state program. If you were eligible for continuation coverage under COBRA or a similar state program, but did not elect and/or exhaust such coverage, the Pre-existing Condition Waiting Period will apply; and
- b) you had at least 18 months of Creditable Coverage with no more than a 62 day lapse in coverage, and your most recent type of coverage was a group insurance plan, government plan, or church plan; and
- c) you are not currently eligible for Medicare or Medicaid; and
- d) you are not covered by any other health insurance plan; or,
2. you are a funded, eligible graduate student, or a dependent of a funded, eligible graduate student who was previously insured during the prior academic year through Primecare and who is now enrolling into the Student Health Insurance Plan without a break in coverage.

Creditable Coverage: This term means the following Hospital, medical, or surgical coverage an Insured Person had prior to the Effective Date under this Plan: (a) an employee group health plan; (b) health insurance or Health Maintenance Organization coverage; (c) Medicare; (d) Medicaid; (e) Chapter 55 of title 10, United States Code. (CHAMPUS); (f) a medical care program of the Indian Health Services or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under the Federal Employee Health Benefits Program; (i) a public health plan as defined under Federal regulations; (j) a health benefit plan under Section 5(e) of the Peace Corps Act; or (k) any other similar coverage permitted under State/Federal law or regulations.

Exceptions: The Pre-Existing Condition exclusion does not apply to any of the following (a) a newborn dependent child for whom application is made within 31 days of birth; or (b) a covered adopted dependent child who is adopted or placed for adoption prior to age 18 and for whom application is made within 31 days of the date of adoption or the date of placement for adoption.

Continuous Insurance

This Policy may be replacing a Prior Plan with another insurer. Prior Plan means (a) the Student Health Insurance policy or policies issued to The Ohio State University immediately before this Policy; and (b) other Creditable Coverage as defined in the Policy.

Injury or Sickness shall include an Injury sustained, or a Sickness first manifesting itself, while the Insured Person is continuously insured under the Prior Plan and became insured under this Policy without a break in coverage.

But no benefits shall be payable for such Injury or Sickness to the extent that such benefits are payable under the Prior Plan for the same Covered Expenses. This will apply even though the Prior Plan provided that it will not duplicate the benefits under another Policy.

Also, the total amount of benefits payable for Injury or Sickness under this Policy and the Prior Plan issued to The Ohio State University cannot exceed the Lifetime Aggregate Maximum.

Exclusions

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

1. Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as gambling, sexual, spending, shopping, working and religious; codependency;
2. Circumcision;
3. Surgical treatment of congenital conditions, except as specifically provided for Newborn or adopted Infants;
4. Cosmetic procedures, except cosmetic surgery required to correct an injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
5. Custodial care such as care provided in rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or custodial care. Extended care in treatment or substance abuse facilities also are not covered for domiciliary or custodial care;
6. Dental treatment, except for accidental injury to sound, natural teeth;
7. Elective Surgery or Elective Treatment;
8. Vision services and supplies related to eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process; or, except as specifically provided in the policy;
9. Foot care including: flat foot conditions, supportive devices for the foot, subluxations of the foot, care of corns, calluses, toenails, fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet;
10. Hearing examinations or hearing aids;
11. Immunizations, except as specifically provided in the Child Health Supervision Services Benefit; preventive medicines or vaccines, except where required for treatment of a covered Injury;
12. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
13. Injury sustained by reason of a motor vehicle accident to the extent that benefits are paid or payable by any other valid and collectible insurance;
14. Injury sustained while (a) participating in any intercollegiate 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;
15. Anything caused by, contributed to or resulting from an organ transplant;

16. Participation in a riot or civil disorder; commission of or attempt to commit a felony;
17. Pre-existing Conditions, except for individuals who have been continuously insured under the OSU Student Health Insurance for at least 90 (ninety) consecutive days; The 90 day waiting period will not apply if the Insured meets the following criteria:
 - a) the Insured elected and exhausted any continuation coverage available under COBRA or a similar state program that was available to the Insured before enrolling under this policy. This specific criteria does not apply if the Insured was not eligible for continuation coverage under COBRA or a similar state program. If the Insured was eligible for continuation coverage under COBRA or a similar state program, but did not elect and/or exhaust such coverage, the Pre-existing waiting period will apply; and
 - b) the Insured had at least 18 months of Creditable Coverage with no more than a 62 day lapse in coverage, and the Creditable Coverage was a group insurance plan, government plan or church plan; and
 - c) the Insured is not currently eligible for Medicare or Medicaid; and
 - d) the Insured is not covered by any other health insurance plan.
18. Prescription Drugs services - no benefits will be payable for
 - a) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
 - b) Products used for cosmetic indications;
 - c) Drugs used to treat or cure baldness; anabolic steroids used for body building;
 - d) Anorectics - drugs used for the purpose of weight control;
 - e) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra;
 - f) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
19. 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; premarital examinations; impotence, organic or otherwise; sexual reassignment surgery;
20. Routine Newborn Infant Care, well-baby nursery and related Doctor charges, except as specifically provided in the policy;
21. Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the policy;
22. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
23. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery, except as made necessary as a result of a covered Injury;
24. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided in the policy; gynecomastia;
25. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
26. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and

27. Weight management services and supplies related to weight reduction programs; weight management programs; related nutrition supplies; treatment for obesity, including gastric bypass surgery and other obesity-related surgeries and procedures, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia except as specifically provided in the policy. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

Collegiate Assistance Program

Insured Students have access to nurse advice and health information 24 hours a day, 7 days a week by dialing the access number indicated on the permanent ID card. College Assistance Program is staffed by Registered Nurses who can help students determine if they need to seek medical care, understand their medications or medical procedures, or learn ways to stay healthy.

Coordination of Benefits (Domestic Students)

Ohio State Law permits Coordination of Benefits when an Insured Person is covered under more than one valid and collectible health insurance plan. A complete description of the Coordination of Benefits provision is included in the Master Policy on file with The Ohio State University.

This provision only applies to Domestic Students.

Subrogation and Recovery Rights

Right to Subrogation: If, after payments have been made under this Plan, any person has the right to recover damages from a responsible third party, Our right will be subrogated to that person's right to recover. The Insured Person will do whatever is necessary to enable Us to exercise Our right and will do nothing after Loss to prejudice it. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

Right to Reimbursement: If benefits are paid under this Plan and any person recovers from a responsible third party by settlement, judgment or otherwise, We have a right to recover from that person an amount equal to the amount We paid. However, We will reimburse the Insured Person for any charges on a pro-rata basis for any expense incurred in securing the settlement, judgment or otherwise.

Limitation to Our Recovery Rights: We may exercise Our Right to Subrogation against responsible third parties unless We are precluded from enforcing such right where a responsible third party has extinguished its liability or has been relieved of liability by contract or operation of law. If We are precluded from exercising Our Right to Subrogation, We may exercise Our Right to Reimbursement.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under this Plan. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a responsible third party.

We, in exercising Our Right to Subrogation, will not seek to recover more than We paid under this Plan. We, in exercising Our Right to Reimbursement, will not seek to recover more than the amount recovered from a responsible third party.

Extension of Benefits

If an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term Expense, but only while they are incurred during the 31 day period following such termination of insurance.

Termination of Coverage

The insurance for an Insured Person shall terminate on the first of the following dates:

- (1) on the date this Plan is terminated; or
- (2) on the premium due date if the required premium for the Insured Person is not paid, except as a result of inadvertent error; or
- (3) as of the date the Insured Person enters military service, in which case a pro-rata refund of premium will be made to such Insured Person; or
- (4) on the date the Insured Person no longer qualifies as an Eligible Person as shown in the Eligibility Provisions.

Termination of Insurance for an Insured Person shall be without prejudice to any claim which starts prior thereto.

Claim Procedures

Claim Filing Instructions: In the event of an Injury or Sickness, the Insured Person should:

If the Wilce Student Health Center is open and you are an Insured Student, report immediately to the Student Health Services so that proper treatment can be administered (this does not apply to covered Dependents).

If the Wilce Student Health Center is closed, report to any Hospital or Doctor and follow that provider's instruction. There are advantages to seeking treatment from a Network Provider. Refer to page 13 of this brochure for details.

For treatment received outside of the Wilce Student Health Center, the Insured Person should file a claim with the Claims Administrator, Klais & Company, Inc. within 90 days after the date of the Injury or commencement of the Sickness, or as soon as reasonably possible.

A claim form is not required to submit a claim. However, an itemized medical bill, HCFA 1500, or UB-92 form should be used to submit expenses. The Insured Student/Person's name, identification number, relationship to student (if dependent), and address need to be included.

The form(s) should be mailed within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Bills submitted after one year will not be considered for payment except in the absence of legal capacity. Retain a copy for your records and mail a copy to the Claims Administrator, Klais & Company, Inc. at the address below.

Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Klais & Company, Inc.

Klais & Company, Inc.

1867 West Market Street, Akron, OH 44313-6977

1-877-349-9017

email: osushipclaims@klais.com

Claims Processing Information: Payment for Covered Services are made within thirty (30) days after receipt of the completed claim. Although Insured Persons may request that payment be made directly to a provider, the Company reserves the right to have payments made to providers or directly to Insured Persons. However, Insured Persons cannot request that payment be directed to anyone else. Once treatment is received from a provider, Insured Persons may not request that payment be withheld.

Appeal Procedure: If a claim is wholly or partially denied, a written notice will be sent to the Insured Person containing the reason for the denial. The notice will include a reference to the provision in the Plan and a description of any additional information which might be necessary for reconsideration of the claim. The notice will also describe the right to appeal. A written appeal, along with any additional information or comments, may be sent within 90 days after notice of denial. In preparing the appeal, the Insured Person, or his or her representative, may review all documents related to the claim and submit written comments and issues related to the denial. After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent within 60 days after receipt of the notice of the appeal. An external review is available once the internal review process has been exhausted. Please contact Klais & Company, Inc. for additional information.

Conversion Plan

Insured Students who have been continuously enrolled under The Ohio State University Student Health Insurance Plan for at least six (6) months are eligible to enroll in the Conversion Plan for up to twelve (12) months of coverage. Upon termination of coverage under the Student Health Insurance Plan, an Insured Student may request continuation of coverage. The Conversion Plan must be purchased within 31 days following the date the Insured Student loses eligibility including the exhaustion of off-term insurance. This Plan is neither endorsed nor administered by The Ohio State University. It is a direct contract between the Insured Student and the Company. The Conversion Plan has a completely separate benefit and rate structure. Full information including coverage, benefits, rates, and an application, is available from Gallagher Koster. The Gallagher Koster will send the Conversion Plan directly to the Insured Student. It is the Insured Student's responsibility to submit the premium according to the terms outlined in the Conversion Plan description of coverage.

This Medical Insurance Plan is underwritten by

UnitedHealthcare Insurance Company

Policy Number: 2010-1098-1 (Domestic)
2010-1098-4 (International)

Contacts / Questions

CUSTOMER SERVICE

Gallagher Koster

500 Victory Road, Quincy, MA 02170
OSUship@Gallagherkoster.com
800-254-2461

www.GallagherKoster.com

For questions about medical & Rx benefits, student or dependent eligibility or enrollment, ID cards, general questions and/or service issues

Klais & Company, Inc.

1867 West Market Street, Akron, Ohio 44313-6977
OSUshipclaims@klais.com
877-349-9017

For questions about medical & prescription claims processing

Students who want to check the status of a claim, can register for Status Link claims look-up at www.klais.com

Collegiate Assistance Program

877-604-2053

24/7 access to nurse advice and health information

Scholastic Emergency Services

www.assistamerica.com

877-488-9833 Toll-free within the United States
609-452-8570 Collect outside of the United States
or via email at medservices@assistamerica.com

For information or assistance for emergency travel assistance services

Student Health Insurance Program

<http://shi.osu.edu>
shi_info@osu.edu
614-688-7979

For questions regarding the Waiver Process, about Wilce Care, or for assistance when encountering problems using the web.

Student Consolidated Services Center

scsc@osu.edu
800-648-6440
320 Lincoln Tower

For questions regarding premium charges and payments, GA subsidy payments and payroll deductions, deadlines, refunds, and other Statement of Account information.

PRE-CERTIFICATION

CareAllies

800-348-1313 (Hospital and Maternity Admissions, Home Infusion Therapy and Medical Emergency)
800/338-9059 (Outpatient Mental Health and Nervous Conditions and Alcohol and Drug Abuse)
For information or notification to meet precertification requirement
For Health Care Providers and Services

PROVIDER INFORMATION AND SERVICES

OSU Health Plan Network

www.osuhealthplan.com

osu-mhcs@osu.edu

614-292-4700

For information about Network Providers & Facilities

Student Health Services

<http://shc.osu.edu>

shs@osu.edu

614-292-4321

For questions about services and to schedule appointments

Counseling & Consultation Service

<http://ccs.ohio-state.edu>

614-292-5766

For questions about services and appointments

College of Optometry Clinics

<http://greatvision.osu.edu>

614-292-4321 (for appointments at Wilce Health Center) or 614/292-2020

(for appointments at 338 W10th Ave., Columbus, OH)

For questions about services and appointments

College of Dentistry Clinics

<http://www.dent.osu.edu/patients>

614-292-2751

For questions about services and appointments

University Medical Center

<http://medicalcenter.osu.edu>

614-293-8000

Information about the services and physicians of OSU Medical Center, University Hospitals East and network of community care facilities throughout central Ohio

Delta Dental of Ohio

www.deltadentaloh.com

800-282-0749

For information about dental benefits & claims, and Delta Network dental services Providers