



Washington University in St. Louis

# Student Health Services Summary Benefits Plan

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Group Number: Med8030

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## INTRODUCTION TO THE STUDENT HEALTH SERVICE

Washington University Student Health Services (either “Student Health Services” or “SHS”) is pleased to provide you with this Summary Benefits Plan Description, which describes the health benefits available to you and your covered family members under the Washington University Student Health program of services (the “Plan”). With this, students and their covered family members should have all the pertinent information to understand what services are available to them through Student Health Services. Keep this booklet for reference during your stay at WUSM.

This Summary Benefits Plan Description covers:

- who is eligible for what services
- what services that are covered
- what services that not covered
- your rights and responsibilities under the Plan

This Summary Benefits Plan Description is designed to meet your informational needs and the disclosure requirements under the Patient Protection and Affordable Care Act. It supersedes any previous printed or electronic Summary Benefits Plan Description for the Plan. This Summary Benefits Plan Description is not to be construed as a contract. **Washington University Student Health Services intends to continue this Plan, but reserves the right, in its sole discretion, to modify, change, revise, amend or terminate the Plan at any time, for any reason, with 60 day notice.**

## WHAT IS THE STUDENT HEALTH SERVICE?

The goal of Student Health Services is to deliver efficient, accessible, high-quality medical care, without undue financial burden, in order to prevent and treat health problems that may interfere with a student’s educational and professional goals while attending WUSM.

Student Health Services provides a multidisciplinary facility conveniently located on campus and dedicated to providing quality health care to WUSM students and their covered family members. The well qualified staff consists of physicians, nurses, psychologist, and other medical support personnel.

Student Health Services is under the direction of Dr. Karen S. Winters. After hours phone service is available to assist those with acute infections or other urgent conditions. Please call **(314) 362-3526** to leave a message for Dr. Karen Winters when SHS is closed.

Student Health Service welcomes your interest and needs your cooperation. If you have any questions or suggestions regarding enrollment or benefits and services as described in this booklet, please contact Betty Feagans at Student Health Services, 4525 Scott Ave, Room 3420, 314-362-2346, email address: feagansb@wustl.edu.

**Student Health Services covers approved expenses not covered by private insurance, or in the absence of private insurance. If you have private insurance, such as coverage through your parents as a dependent, all bills should be submitted to your insurer before filing through the Student Health Service.**

## GENERAL INFORMATION

### Location:

4525 Scott Ave  
Third floor, East Building, Room 3420

### Hours:

Open: 8:00 a.m. – 4:00 p.m. Monday through Friday (Any changes in hours will be posted at entrance)  
Closed: Saturday, Sunday, and University holidays.

### Telephone Numbers:

General Information, Appointments, Medication Refills	(314) 362-3523
After Hours Voice Mail	(314) 362-3526
Billing/Benefits	(314) 362-2346

**Web site:** <http://wusmhealthservice.wustl.edu>

**After Hours email Service** - For urgent needs only, not routine questions or appointments. . **Dr. Karen Winters: [kwinters@wustl.edu](mailto:kwinters@wustl.edu)**

**Physicians** - By appointment only. Telephone early in the day if you need to be seen the same day.

**Nursing** - If the problem is urgent and a physician is not present, the nursing staff will assess your need.

**Counseling** - By appointment only. No referral needed.

**Student Assistance Program** – This service is available 24/7 by calling **1-800-327-2255**

**Dental Plan** – Sun Life Customer Service at **1-800-443-2995**

**Dermatology** - By appointment only, by calling Division of Dermatology. No referral needed.

**Allergists** - By appointment only. Referral required from Student Health Service physician.

**Ophthalmology** – By appointment only, by calling the Vision Center. No referral needed.

**Pharmacy** – Full service, most medications are provided at the time seen. Requests for refills may be phoned in 8:00 a.m. – 4:00 p.m. Monday-Friday. Allow 4 hours for refilling.

**24-Hour Reporting System** - All animal, human and laboratory blood/body fluid exposures should be **reported immediately** to Student Health Services 24-hour reporting system. During working hours, 8:00 a.m. – 4:00 p.m., the office can be reached at **(314) 362-3523**. After hours, Student Health Services can be contacted through a digital pager at **(314) 871-2966**. There is a post-exposure card available for your reference. For more information regarding exposures view our web site at <http://wusmhealthservices.wustl.edu>.

**Health Statements** - Student Health Services will provide students with exit statements of health for internships (but you must schedule them with Student Health Service) and with immunization letters, if needed. The first exit statement of health for internships will be provided at no charge. Any additional copies/requests will be provided for a service fee.

## STUDENT HEALTH SERVICES AFTER HOURS

Student Health Services provides after hours email coverage. The After-hour email exchange: [kwinters@wustl.edu](mailto:kwinters@wustl.edu).

Your message should include a phone number and/or beeper where you may be reached at the specified message retrieval hours, as well as your name, school, and a brief message about your concerns. Please have a pharmacy number available if you believe medications may need to be prescribed.

This service is intended to be used by those with acute infections or other urgent conditions. **This service is not for true emergency medical conditions.** If you or a Covered Dependent have a true emergency medical conditions and are in need to emergency medical services, then you should proceed to the Barnes-Jewish Hospital Emergency Room or other emergency room immediately.

## IDENTIFICATION CARDS

At the time of orientation, all new Students will be given a Medical Benefit Identification card. Covered Dependents will be given a Medical Benefit Identification card upon enrollment in the Plan. This card should be shown to all caregivers outside of Student Health Services to ensure proper billing. If you need a replacement card, you may pick one up at Student Health Services.

## ELIGIBILITY

Participation in the Student Health Services Plan is required for all full-time students enrolled in the medical or allied professional schools of Washington University in St. Louis School of Medicine (WUSM). All WUSM full-time, medical students are automatically charged for the health fee and enrolled in the Student Health Services Plan at the time they register for classes. There is no waiver for this fee based on existing health insurance coverage.

A full-time student's "Eligible Dependent" may also participate in the service. An Eligible Dependent is a "Spouse," "Domestic Partner," or "Eligible Child" (as defined below) of the Student.

- A "Spouse" is an individual to whom the student is legally married (as determined under applicable state law at the time and location where the marriage was performed), who resides with the Student, and is not eligible for coverage through his or her school or employer.

- A "Domestic Partner" is as an individual of the same or opposite sex who resides with the Student, and is not eligible for coverage through his or her school or employer and with whom the student has established a domestic partnership. A domestic partnership is established when both persons are:
  - not be so closely related that marriage would otherwise be prohibited;
  - not be legally married to, or the Domestic Partner of, another person under either statutory or common law;
  - be at least 18 years old;
  - live together and share the common necessities of life;
  - be mentally competent to enter into a contract; and
  - be financially interdependent.

In order to cover a Domestic Partner, a student must complete a domestic partner affidavit.

- An "Eligible Child" is the Student's child, the Spouse's child, or the Domestic Partner's child, as long as the child:
  - is under 26 years of age; and
  - is the biological child, stepchild, or legally adopted child of the Student, Spouse, or Domestic Partner, or a child placed with the Student, Spouse, or Domestic Partner for adoption, or a child for whom the Student, Spouse, or Domestic Partner is the legal guardian.
  - will add a \$80 monthly surcharge to the plan access fee for students electing to enroll a child who is eligible for health premiums through someone other than the student. The surcharge will be in addition to the applicable Washington University School of Medicine Student Health access fee.

**Once an Eligible Dependent is enrolled in the plan they are considered a "Covered Dependent." Students and Covered Dependents together are considered "Covered Persons." Student Health Services does not discriminate on the basis of pre-existing conditions or health status at the time of enrollment. If a Spouse, Domestic Partner, or Covered Child is denied enrollment in the Plan, they may appeal using the appeal procedure found toward the end of this booklet. Part-time students, Danforth campus students, and their dependents are not eligible to participate in the Student Health Services Plan.**

## ENROLLMENT AND COST OF COVERAGE

Students and Washington University share in the cost of the Student Health Services Plan. **Full-time WUSM students will be automatically enrolled in the Student Health Services program of services upon registration for classes.** Students may enroll their Eligible Dependents in the program by submitting an enrollment form and paying the applicable Student Health Service access fee within thirty one (31) days of a Qualifying Event as defined below. The access fee will depend on the Eligible Dependents the student chooses to enroll.

The Student Health Service access fee for all Covered Dependents must be paid directly to Student Health Service. The entire first month's payment is due at the time of enrollment and will not be pro-rated if enrollment occurs after the first day of the month. The access fee for each Eligible Dependent is:

- Spouse or Domestic Partner: \$4,560.00 per year (\$380.00 per month);
- Eligible Child: \$2,016.00 per year (\$168.00 per month) per child.
  - will add a \$80 monthly surcharge to the plan access fee for students electing to enroll a child who is eligible for health premiums through someone other than the student. The surcharge will be in addition to the applicable Washington University School of Medicine Student Health access fee

Enrollment application must be made through the Student Health Services, 4525 Scott Ave, Suite 3420.

Student contributions and access fees are subject to review, and Washington University reserves the right to change student contribution or access fee amounts at any time upon sixty (60) days' notice. You can obtain current contribution rates and access fees by calling Student Health Service.

## QUALIFYING EVENTS

The following are allowed Qualifying Events: enrollment for full-time classes at WUSM, marriage, divorce, death, legal separation, termination of employment, Spouse's initial arrival to the United States, birth of an Eligible Child, legal adoption of an Eligible Child, grant of legal guardianship over an Eligible Child

The Qualifying Event can occur any time during the year. When a Qualifying Event occurs, the Student must notify the University of the Qualifying Event (except at the time of the Student's initial enrollment). Students may be required to submit a Dependent Verification Affidavit and supporting documents to provide proof of first-time eligibility to Washington University within thirty one (31) days of the Qualifying Event. Students must fill out an Enrollment Form and pay the required Student Health Service access fee within thirty one (31) days of the Qualifying Event to enroll the Eligible Dependent for the Plan. An Eligible Dependent (except Newborn Infant) will be enrolled and eligible for benefits at the time the University receives the Enrollment Form and at least the first month's payment of the appropriate access fee.

Newborn Infants will be covered under the program for routine nursery care for newborn children for up to 96 hours after a caesarean section delivery and for up to 48 hours after any other delivery. Newborn infant means any child birthed by a Student, Spouse, or Domestic Partner while that person is covered under this program. Only the Student will have the right to continue such coverage for the child beyond the first 48 or 96 hours. If the Student does not use this right as stated here, all coverage to that child will terminate at the end of the applicable 48 or 96 hour period after the child's birth. To continue the coverage, the Student must, within thirty one (31) days after the child's birth, complete and return the

Qualifying Event Form with payment of the Eligible Child access fee to Washington University. If properly submitted within this initial thirty one (31) day period, enrollment for the newborn will be retroactively effective back to the date of birth. A newborn child of a Student's Covered Child (e.g. the Student's grandchild) is not eligible to continue coverage beyond the initial 48 or 96 hour period.

Washington University may require annual verification of eligibility for all Dependents enrolled in the program of services. The annual verification of Dependent eligibility will be conducted as part of the process to ensure that health benefits are being provided fairly and consistently to eligible Dependents. It is anticipated that this process will take place in August of each year. It is the Student's responsibility to provide materials ensuring the timely verification of eligible Dependents each policy year.

## WHEN COVERAGE BEGINS AND ENDS

Benefits are payable under this program only for those Covered Medical Expenses incurred while the Program is in effect. No benefits are payable for expenses incurred after the date the benefits terminate. This program terminates for all Covered Dependents once the primary member is no longer a full-time student, when the Covered Dependent no longer meets the definition of an Eligible Dependent as described above, or if the Student Health Service access fee for Covered Dependents has not been received. There will be a thirty one (31) day grace period for late payment of the access fee, after which time, coverage for the Covered Dependents will be terminated. If Covered Dependent coverage is terminated due to lack of sufficient payment, all Eligible Dependents of that Student will not be allowed to enroll or reenroll for coverage at any time in the future. Student Health Services reserves the right to terminate the Plan if the Plan is terminated as it relates to all Students or similarly situated Covered Dependents.

If a Student elects to enroll his or her Eligible Dependents at matriculation, coverage for those dependents will become effective on the same date the Student's benefits become effective, provided enrollment for the Eligible Dependents occurs on or before the thirty one (31) day deadline. No enrollment for Eligible Dependents is allowed after the deadline unless a Qualifying Event occurs. When Dependents, other than Newborn Infants, enrolls based on a later Qualifying Event, their coverage becomes effective as of the day the access fee payment is received and an Enrollment Form is completed, or a later date as specified by the Student or Eligible Dependent. Newborn Infants entering the program within the initial thirty one (31) day period after the birth will have coverage effective retroactive to the date of birth.

Once a Student or Covered Dependent has been enrolled, Student Health Services shall not rescind acceptance into the Plan, except when the Student or Covered Dependent has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact regarding their eligibility to enroll.

**Student Health Services:** All Student Health Services benefits take effect on the date coverage otherwise begins, continue so long as the Student maintains full-time student status, and, except for Hospital and Emergency Room Services, cease on the date the Student withdraws, graduates, or completes a course of study by submitting thesis paperwork to the appropriate office. Enrolled Covered Dependent coverage will terminate the date the primary member is no longer a full-time student. Hospitalization and emergency room benefits ceases thirty (30) days after the Student graduates, withdraws, or completes a course of study by submitting all thesis paperwork to the appropriate office.

**Away from Campus:** Special rules apply when the student is away from campus. There are limited benefits provided through Student Health Services, which are described later in this booklet.

**Travel Outside of the U.S.:** Student Health Services does not provide **any** coverage for you or Covered Dependents when traveling outside of the United States. You are encouraged to take advantage of the Medical Plan for International Travel and you may obtain more information on that plan from Student Health Services.

## LEAVE OF ABSENCE

If you wish to continue Student Health Services benefits while on a leave of absence, you will be required to pay the Student Health Services access fee, in addition to the deductibles and co-payments paid by active students. The enrolled dependents may remain enrolled in the program while when the primary member is on an approved leave of absence so long as the primary member continues coverage. The enrolled dependent will not be eligible to remain on the Student Health Services program if the primary member suspends coverage while on leave. The Student Health Services fee must be paid within 30 days of the effective date of the leave and, thereafter, is required to be paid monthly, in advance, at the beginning of the calendar month. If Student Health Services does not receive payment within five days of the beginning of the month, coverage will terminate. Student Health Service benefits are available to a student on leave for a maximum of 24 months (which need not be consecutive). If during the leave the student carries the status of employee and/or eligible for employee benefits, this will make them ineligible to enroll in the Student Health Service benefits.

Students requiring a leave of absence for medical reasons must submit a supporting letter from the Director of the Student Health Service.

## REFERRAL REQUIREMENT FOR STUDENTS, SPOUSES AND DOMESTIC PARTNERS

Students and Covered Dependents over the age of 18 (all a “Covered Adult”) should seek treatment at Student Health Services for all medical conditions, even if the Student is on a medical leave of absence. If Student Health Services is unable to provide the care needed and the care is a Covered Service, you must obtain a referral or pre-approval from Student Health Services for a visit to a WUSM Participating Physician (the “In-Network providers”) to be covered by the Plan. If both Student Health Services and the In-Network provider are unable to provide the care needed and the care is a Covered Service, Student Health Services will provide a referral to receive treatment outside of Student Health Services In-Network (the “Out-Network providers”). A separate referral is required for each individual condition, and at the beginning of each year prior to receiving care for ongoing conditions. If a Covered Adult does not obtain a referral prior to treatment, benefits are not payable by Student Health Services.

You will need to pay some out of pocket expenses if referred outside of Student Health Services. Please see the **Summary of Benefits and Coverage** for a summary of expenses for In-Network and Out-Network fees.

If a Covered Adult is unable to access Student Health Services (for example, while away from WUSM) then pre-approval is required before SHS will cover any medical expenses, except as provided below. Upon returning to WUSM, the Covered Adult must return to Student Health Services for any necessary follow-up care or referrals. When the Student Health Service is closed for urgent medical needs contact the after hour phone service for approval, for non-urgent medical needs contact the office the next business day.

**Except as otherwise provided below, the Plan will not pay benefits to an In-Network or Out-Network provider without a referral or pre-approval from Student Health Services. Without a referral or pre-approval, you will be responsible for 100% of the costs.**

A referral from SHS is not required for services from the following providers in order to be covered according to the terms in this Plan:

- Emergency and urgent services treatment as required to stabilize the patient. (Once stabilized, Covered Adults are required to obtain a referral or pre-approval from Student Health Services for any necessary follow-up care the following business day);
- For Obstetrical or Gynecological care provided by a Student Health Service participating health care professional who specializes in gynecology. Care for Covered Children at Forest Park Pediatrics or with a referral from Forest Park Pediatrics;
- Care from the WU Division of Dermatology;
- Counseling Services from an In-Network Psychologist; and
- Care from the Barnes-Jewish Vision Center.

## **COVERED CHILD COVERAGE**

A Covered Dependent under the age of 18 (a “Covered Child”) is not eligible to be treated at the Student Health Center. All outpatient care is provided by:

Forest Park Pediatrics, P.C.  
4488 Forest Park Ave, Suite 230  
St. Louis, MO 63108

Office Hours:

Monday – Friday 8:00 a.m. – 5:00 p.m.

Saturday 8:00 a.m. – 12:00 p.m.

Office: **(314) 535-7855** -- Emergency Exchange: **(314) 362-4433**

Forest Park Pediatrics will serve as the Pediatric Primary Care Physicians for the Covered Child. Forest Park Pediatrics will provide routine preventive and primary care services rendered to a Covered Child on an outpatient basis.

**Except as otherwise provided, the Plan will not pay benefits to an Out-Network provider without a referral or pre-approval from Forest Park Pediatrics. Without a referral or pre-approval, you will be responsible for 100% of the costs.**

**You will be charged \$20.00 for any appointment missed without notice.**

## **PREVENTATIVE HEALTH SERVICES**

### **U.S. Preventative Services Task Force Recommendations**

Preventative services that have a rating of A or B from the US Preventative Services Task Force (USPSTF) that are recommended by the USPSTF for a person matching the Student or Covered Dependent’s description will be 100% covered by Student Health Services when treatment is rendered at the Student Health Service. Student Health Services reserves the right to deny coverage for services that are not recommended by the USPSTF if they do not meet other eligibility criteria.

Covered Adults must seek USPSTF recommended preventative services from Student Health Services for the services to be covered. A Covered Child should seek USPSTF recommended preventative services from Forest Park Pediatrics for the services to be covered.

These services are covered only when delivered by a doctor or provider in your plan's network. Please see [www.healthcare.gov/preventive-care-benefits/](http://www.healthcare.gov/preventive-care-benefits/) for complete details of the services provided for specific age and risk groups.

## **Immunizations**

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Student Health Services will provide all Center for Disease Control (CDC) Advisory Committee for Immunization Practices (ACIP) adult recommended vaccines free of charge if the Covered Adult meets the eligibility criteria (These services are limited to Student Health Service and Forest Park Pediatrics Providers only. Immunization are not covered by any other provider.. All other vaccines will be provided at cost.

Pediatric immunizations are provided by Forest Park Pediatrics. Pediatric travel immunizations are provided by Forest Park Pediatrics. Student Health Services will provide all Center for Disease Control (CDC) Advisory Committee for Immunization Practices (ACIP) recommended vaccines free of charge from birth to age 18 if the Covered child meets the eligibility criteria. All other vaccines will be provided at cost.

For any other vaccine, Students and Covered Dependents will be responsible for an 80% coinsurance requirement and Student Health Services will cover twenty percent (20%) of the charges and you will be responsible for the remaining cost.

## **Children's Preventative Health Services**

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A Covered Child is not eligible to utilize Student Health Services. Therefore, a Covered Child should seek all recommended preventative care and screenings as determined by the Health Resources and Services Administration from Forest Park Pediatrics. Such HRSA recommended preventative care and screenings shall be provided free of charge.

## **Women's Preventative Health Services**

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All preventative services outlined in the Human Resources and Service Administration's "Women's Preventative Services Guidelines" as necessary to women's health and wellbeing shall be covered free of charge by Student Health Services. Including Breast Cancer Genetic Test Counseling (BRCA) for women at higher risk for breast cancer.

Student Health Services pharmacy shall provide FDA approved generic contraceptive methods including brand name that has no generic equivalent or when required by your doctor due to medical necessity free of charge.

## **Surgical Sterilization Health Services**

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Female sterilization procedure when it is performed as a the primary procedure for family planning reasons. If you are seen at an In-Network provider Student Health pays 50% of the reasonable and customary covered expenses and waive any co-insurance. Not covered out of network.

Reversals of sterilizations are not covered. Sterilization services Out-of-Network are not covered.

## OUTPATIENT SERVICES

### Primary Care Outpatient Services

Student Health Services will provide unlimited outpatient care and treatment usually performed in a primary care physician's office, at no charge. Student Health Services physicians are seen by appointment only. If the problem is urgent and a physician is not present, the nursing staff is available during office hours to assess your need.

A Covered Child is not eligible to utilize Student Health Services and instead should seek primary care outpatient services from Forest Park Pediatrics.

**You will be charged \$20.00 for any appointment missed without notice.**

### Specialty Care Outpatient Services

Except as otherwise noted in this policy, if you need specialty care outside of Student Health Services, you must obtain a referral or pre-approval from Student Health Services to see an In-Network participating specialist for any expenses to be covered by the Plan. Unless otherwise stated in this policy, you will be responsible for a copayment of \$20.00 for each visit to a specialist, collected at the time seen. When prior approved by Student Health Out-Network provider, Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such covered expenses.

**You must return to the Student Health Services with all medication prescriptions and diagnostic testing orders for such prescriptions or orders to be covered by the Plan.** Except as otherwise preapproved by Student Health Services, all prescriptions and diagnostic testing must be obtained through the Student Health Services for coverage.

A Covered Child is not eligible to utilize Student Health Services and instead should obtain a referral from Forest Park Pediatrics. A Covered Child should return to Forest Park Pediatrics diagnostic testing orders.

## OUTPATIENT – SURGERY SERVICES

The Plan pays for surgery and related services received on an outpatient basis at a Hospital or Alternate Facility or in a Physician's office.

Benefits under this section include:

- the facility charge and the charge for supplies and equipment;
- certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy and hysteroscopy); and
- Physician services for radiologists, anesthesiologists and pathologists.

If you are seen at an In-Network provider (i.e., Barnes-Jewish Hospital, Barnes-Jewish West County Hospital, or Missouri Baptist Medical Center), Student Health Services will pay 100% of the covered expenses.

If you are seen at an Out-Network provider, Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such covered expenses. Only when pre-approved by Student Health Service.

Second surgical opinions must be rendered by a board-certified specialist in the treatment of your particular medical condition, who is not associated professionally or financially with the physician that provided the first surgical opinion consultation. One additional consultation, as a third opinion, is covered in cases where the second opinion disagrees with the first. To avoid unnecessary duplicate testing, you should provide the specialists rendering the surgical opinions with any test results from the doctor who initially recommended surgery.

## WELLNESS SERVICES

Covered Adults may obtain information on exercise, nutrition, smoking, and communicable diseases, and breast examinations, as well as any other appropriate United States Preventative Services Task Force A or B recommended service, only at Student Health Services.

Covered Children are not eligible to utilize services from Student Health Services and should seek wellness services from Forest Park Pediatrics.

## ALLERGY SERVICES

**You must have a referral from Student Health Services in order to schedule an appointment with the allergist.** You will be referred to a Student Health Services In-Network participating specialist. You will be responsible for a copayment of \$20.00, collected at the time seen. You will be responsible for an immunotherapy start-up fee of \$100.00. An additional fee for re-starting immunotherapy will be charged for non-compliant immunotherapy regime.

Student Health Services offers continuous care for Students, Spouses and Domestic Partners receiving allergy injections prescribed by the allergist. The nursing staff is available for injections that have been ordered by your allergist. Allergy injections are given Monday through Friday from 8:00a.m. – 3: 00 p.m. and require a 30 minute waiting period after the injection is given. There is a \$10.00 fee per allergy injection visit.

A Covered Child is not eligible to utilize Student Health Services to schedule an appointment with an allergist or for allergy injections, and instead should seek a referral or care from Forest Park Pediatrics.

## DERMATOLOGY SERVICES

Students and Covered Dependents do not need a referral from Student Health Services or Forest Park Pediatrics for Dermatology Services to be covered by the Student Health Services Plan. These services will be provided by the Division of Dermatology faculty at either the 5<sup>th</sup> floor of the Center of Advanced Medicine (CAM) Dermatology Clinic or the General Dermatology Clinic in West County. You will be charged a \$20.00 copayment per visit, collected at the time seen.

For your convenience you may schedule an appointment at the Center of Advanced Medicine Dermatology Clinic by calling (314) 362-2643 or the General Dermatology in West County by calling (314) 996-8010. When calling for an appointment, please identify yourself as a WUSM medical campus Student or Covered Dependent.

## MENTAL HEALTH SERVICES

Student Health Services provides on-site psychological counseling for Covered Adults (the “In-Network Psychologists”). The initial assessment by the In-Network Psychologists will be provided free of charge. At subsequent visits, Students and Covered Dependents are responsible for a \$10.00 copayment directly to the provider. (Research demonstrates that some financial contribution increases a student’s investment in counseling. Exceptions maybe discussed where there are financial barriers.) When prior approved by Student Health Out-Network provider, Student Health Services will pay 50% of the reasonable and customary covered expenses and you will be responsible for 50% of such covered expenses upto 6 visits.

Priority for counseling services is given to students whose problems may result in poor academic functioning. If you are referred by a CAES Committee or by an academic advisor, you will be seen as soon as possible. Your written HIPAA compliant authorization is required for communication between the University and Student Health Services on any issue regarding your mental health. Please refer to the HIPAA Privacy Notice provided by the Student Health Service for specific information regarding HIPAA compliant authorizations.

**You will be charged \$20.00 for any appointment missed without notice at either Student Health Services or the In-Network Psychologists office.**

Additional psychological counseling for all Student Health Services Plan participants, including a Covered Child, may be provided in private offices. You do need a Student Health Services physician’s or Forest Park Pediatric physician’s referral to see a psychiatrist. A list of Network counselors and psychologists is available in the Student Health Services office.

If you are having difficulty making an appointment or are not pleased with your evaluation or treatment, please make an appointment with one of the physicians at Student Health Services or talk to one of the nurses.

Students are also encouraged to seek the support of peer groups such as Student Support Services and the Student Advisory Committee. These groups seek to provide an avenue by which students can learn to balance their own needs in the midst of their graduate training.

Mental Health Services include those received on an inpatient basis in a Hospital or Alternate Facility, and those received on an outpatient basis in a provider’s office or at an Alternate Facility. Benefits include the following services provided on either an outpatient or inpatient basis:

- Diagnostic evaluations and assessment;
- Treatment planning;
- Referral services;
- Medication management;
- Individual case management services;
- Crisis intervention;
- Partial hospitalization/day treatment; and

- Intensive outpatient treatment.

Inpatient Mental Health/Substance Use Disorder determines coverage for all levels of care (including Partial Hospitalization/Day Treatment and services at a Residential Treatment Facility). If an inpatient stay is required, it is covered on a semi-private room basis. All inpatient admissions, including length of stay, must notify Student Health Services either three (3) business days prior for planned admissions or two (2) business days following emergency admissions. In the event of an emergency, you, your representative, your physician, or the hospital should telephone Student Health Services. Notification does not guarantee the payment of benefits for inpatient admission. Each claim is subject to eligibility, benefits, and medical necessity review and a review of adherence to notification guidelines in accordance with this booklet.

If you are hospitalized at an In-Network hospital (i.e., Barnes-Jewish Hospital, Barnes-Jewish West County Hospital, or Missouri Baptist Medical Center), you are responsible for a copayment of \$500 per hospital inpatient admission. Student Health Services will pay 100% of the remaining covered expenses.

If you are hospitalized at an Out-Network hospital, Student Health Services will pay 50% of the reasonable and customary covered expenses and you will be responsible for 50% of such expenses.

## **STUDENT ASSISTANCE PROGRAM - NexGen**

### **Program Summary**

Student Health Service provides a Student Assistance Program (SAP) for all enrolled students and their immediate family members free of charge and without referral. The SAP provides confidential, professional assistance to full-time enrolled students and their family members to help resolve problems that are affecting their personal life or school performance. The program is managed by ENI, a nationally known professional consulting firm specializing in SAP services. This prepaid benefit is offered as a way to help our Students resolve issues that may have an impact upon their personal lives and their school performance.

Students and family members can contact ENI 24 hours a day, 7 days a week to arrange a confidential appointment with an SAP specialist. SAP specialists have professional training and expertise in a wide range of issues such as academic problems, eating disorders, credit problems, adjusting to school, marriage and family problems, alcohol and drug abuse, emotional, bereavement counseling and psychological concerns, financial difficulties, stress and much more.

The SAP can be reached by calling or text 1-800-327-2255 then press prompt #3. Live chat online at [www.nexgeneap.com](http://www.nexgeneap.com) or use the NexGenEAP mobile app. The company ID 8591.

A detailed description of the plan is available at Student Health Services.

## **PRESCRIPTION DRUG BENEFITS**

### **Student Health Service Dispensary For Students and Enrolled Spouses/Domestic Partners**

Student Health Services maintains a full on-site prescription medication in-network dispensary, and most medications are provided at the time seen. For medications received from the Student Health

Services on-site prescription medication dispensary, you will be responsible for twenty percent co-insurance, depending on the type of medication and cost. We encourage you or your provider to call Student Health Service to ensure your medication is stocked. Requests for refills may be phoned to (314) 362-3523, Monday – Friday, 8:00 a.m. – 4:00 p.m. Allow four hours for refilling. If, at any time, you are unable to pick-up your medication during normal business hours, you may request your medication be placed in the after hour lock box outside the door of Student Health Service.

### **Center for Advanced Medicine (CAM) Pharmacy**

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If a medication is not available through Student Health Services on-site prescription medicine (in-network) dispensary, Students will be given a prescription to fill at the CAM Pharmacy. Covered Children are not eligible to utilize Student Health Services prescription medication dispensary and instead should fill all covered medication at the CAM Pharmacy. Please present your Medical Benefit Identification card when picking up your medication.

The cost of prescriptions filled at CAM pharmacy will be charged to Student Health Service. So long as the medications are pre-approved by or coordinated through Student Health Services in advance, Student Health Service will cover eighty percent (80%) of the charges and bill you for a twenty percent (20%) coinsurance payment, which is payable to Student Health Service. **If the medications are not approved by or coordinated through Student Health Services in advance, there is no coverage and you will be responsible for the entire cost of the prescription.**

CAM Pharmacy Location:

Center for Advanced Medicine

4924 Parkview

3rd Floor

St. Louis, MO 63110

- Monday through Friday 6:30 a.m. to 5:30 p.m.
- Saturday 7:00 a.m. to 3:00 p.m.
- Closed Sundays and most major holidays.

Contact Phone #: 314- 657-9006

### **Off Campus (out of network) Pharmacy**

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If a medication is not available through Student Health Services on-site prescription medicine (in-network) dispensary, Students and Covered Dependents may also obtain approved prescriptions at an off campus retail pharmacy. You must pay in full at the time of service and seek reimbursement from Student Health Service. So long as the medications were pre-approved or coordinated through Student Health Services in advance, Student Health Service will reimburse you eighty percent (80%) of the charges. Covered medications are limited to Generic form drugs, unless a Generic form is unavailable or dispensing the Name Brand drug was pre-approved by Student Health Service. A resource to reduce the cost is free saving using [www.GoodRX.com](http://www.GoodRX.com).

### **Other Prescription Drug Benefits and Qualifications**

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**Travel Abroad Benefits:** Student Health Services will provide coverage for medications to Students and Covered Dependents when they are traveling abroad. Student Health Services will reimburse you twenty percent (20%) of the cost of such medications and you are responsible for the remaining cost. If your program is sponsoring your travel, your medication expenses may be able to be added to the grant or travel budget. You should check with your program coordinator.

**Specialty Medications Costing Over \$250 per month:** For Student Health Service approved medications dispensed at Student Health Services exceeding \$250.00 per month per prescription, you will be responsible for a twenty percent (20%) coinsurance payment for medication approved by Student Health. For Specialty Medication Over \$250 dispensed outside Student Health Service dispensary are NOT covered. For such medications, you are encouraged to apply for patient assistance. Patient assistance programs are available from many drug companies for those people whom are un-insured. Patients needing assistance are encouraged to speak with the providers office or search for programs applicable to their medication at [rxassist.org](http://rxassist.org) to access application forms and contact information. Eligibility for each program varies and often depends on income.

**No Benefits For:** There are no prescription drug benefits for:

- Medication filled from an outside pharmacy without Student Health Services pre-approval
- Specialty Drugs filled outside of Student Health Service
- Over-the-counter drugs – unless recommended by a physician
- Weight reduction drugs
- Drugs used for cosmetic purposes
- Performance-lifestyle drugs

## DIAGNOSTIC TESTING SERVICES

Laboratory testing ordered by an In-Network provider may be obtained through Student Health Services at no charge. Except as otherwise approved by Student Health Services, all blood work should be obtained through the Student Health Services for covered expenses. If a physician outside of Student Health Services orders laboratory testing, you should return the requisition/order to Student Health Service for processing.

Diagnostic testing; including colonoscopy screening, EKG, EEG and other electronic diagnostic medical procedures ordered by and/or approved by Student Health. If you are seen at an In-Network provider i.e., Barnes-Jewish Hospital, Barnes-Jewish West County Hospital, or Missouri Baptist Medical Center), Student Health Services will pay 100% of the covered expenses. Testing performed without approval will not be covered.

If you are seen at an Out-Network provider for diagnostic testing, Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such covered expenses.

Covered Children must obtain an order for diagnostic tests from Forest Park Pediatrics or from a specialist through a referral from Forest Park Pediatrics.

## GENETIC TESTING AND COUNSELING SERVICES

Genetic Testing and Genetic Counseling are covered when Medically Necessary and may be obtained with a referral from Student Health Services. Only U.S. Preventative Services Task Force (USPSTF) testing and counseling pre-approved by Student Health Service will be provided at no copayment. Student and Covered Dependents will be responsible for a 50% coinsurance payment for any other Medically Necessary student Health approved testing and counseling. Benefits are not covered out-of-network.

## DIABETIC SUPPLIES AND EQUIPMENT

Student Health Services covers 80% of the reasonable and customary charges incurred in connection with the management and treatment of diabetes, diabetic testing supplies and insulin pumps based upon the medical needs. You will be responsible for a 20% coinsurance payment. Speciality medication limitation apply.

## DURABLE MEDICAL EQUIPMENT

Student Health Services covers 80% of the reasonable and customary charges for medically necessary Durable Medical Equipment (DME). You are responsible for a 20% copayment. Benefits are not covered out-of-network.

If more than one piece of DME can meet your functional needs, you will receive Benefits only for the most Cost-Effective piece of equipment. Benefits are provided for a single unit of DME (example one insulin pump) and for repairs of the unit.

Student Health will assist in evaluating the need for artificial appliances, such as eye glasses, hearing aids, braces, orthotics, or biofeedback programs. The plan covers approved DME that is:

- ordered or provided by a Physician for outpatient use;
- used for medical purposes;
- not consumable or disposable;
- not of use to a person in the absence of a Sickness, Injury or disability;
- durable enough to withstand repeated use; and
- appropriate for use in the home.

In the Case of covered Children under age 26, Foot orthotics -orthotics or other supportive devices of the feet when prescribed for treatment of an injury or other medical condition of the foot, including braces, splints, insoles, and foot supports constructed of acrylic, plastic, or metal, which are rigid or semi-rigid support items only. As well as impression cast required for the fitting of those devices. The device must be intended for wear at all times that shoes are worn and not just for specific activities. The plan does not cover shoes or supports that are available without prescription.

Replacement hearing aids are available only once every three years.

## PHYSICAL THERAPY OUTPATIENT SERVICES

Physical therapy is covered if medically necessary. An annual limit of 40 visits per academic year applies to outpatient unless an extension is pre-approved by Student Health Services. Referral is required from Student Health Service or, from Forest Park Pediatrics in the case of a Covered Child. If you are seen at an In-Network provider, Student Health Services will pay 100% of the covered expenses.

Physical therapy: the treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; bio-mechanical and neuro-physical principles; and devices to significantly relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part (does not include maintenance therapy). These services must be provided by a licensed physical therapist;

## REHABILITATION and HABILITATION SERVICES

Occupational therapy, speech therapy, pulmonary therapy and cardiac rehabilitation are covered if medically necessary. An annual limit of 20 outpatient and 45 inpatient therapy visits per academic year for treatment of Cerebral Vascular Accidents, head injury, spinal cord injury or as required as a result of post-operative brain surgery applies. For all other diagnoses, 40 outpatient therapy visits per academic year applies. Student Health Services Referral is required from Student Health Service or, from Forest Park Pediatrics in the case of a Covered Child. Rehabilitative care is designed to provide coverage for an accidental or medical injury (e.g., spinal cord injury, closed or open head injury, stroke etc.) The intent of the benefit is to return the patient to the physical status they were at (as much as possible) prior to the injury. If you are seen at an In-Network provider, Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such expenses. Benefits are not covered out-of-network.

Therapies, including:

- Chemotherapy (inpatient and outpatient)—the treatment of malignant disease by chemical or biological antineoplastic agents, including the cost of the antineoplastic;
- Dialysis treatment—the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis;
- Occupational therapy—the treatment of a physically disabled person by means of constructive activities designed and adapted to significantly improving the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living in the home setting (does not include maintenance therapy);
- Radiotherapy (inpatient and outpatient)—the treatment of disease by x-ray, gamma ray, accelerated particles, measons, neutrons, radium or radioactive isotopes;
- Respiration therapy—the introduction of dry or moist gases into the lungs for treatment purposes;
- Speech therapy—the treatment for the correction of a speech impairment when therapy is aimed at restoring the level of speech the individual had attained before the onset of a condition. Speech therapy for developmental disorders, such as stuttering, articulation disorders, tongue thrust, lisping, etc. is not covered;

## CHIROPRACTIC CARE

Benefits will be paid the same as any other Sickness for the chiropractic care delivered by a licensed chiropractor. Benefits will include diagnosis and clinically appropriate and Medically Necessary services and supplies required treating the diagnosed disorder. Benefits will provided for the initial fifteen (15) visits per academic year. In order to receive benefits for any additional visits, the insured must notify Student Health prior to receiving any additional visits. Review of Medical Necessity will be performed for any follow-up diagnostic tests or visits for treatment in excess of the initial twenty-six visits. Benefits shall be subject to 20% co-insurance, limitations or any other provisions of the plan. Referral is required from Student Health Service or, from Forest Park Pediatrics in the care of Covered Child.

## OBSTETRICAL/GYNECOLOGICAL CARE

Women's preventative health care services for Students, Spouses, and Domestic Partners are performed at Student Health Services. Preventative Health and other services provided by Student Health Services will be provided free of charge, no referral is required. Complications will be referred to an Obstetrics and Gynecology practice out side of Student Health, where you will be responsible for a \$20.00

copayment.. Obtaining covered care from an Out-Network provider requires pre-approval by Student Health Services, where you will be responsible for 20% coinsurance.

Any provider must notify Student Health Services of treatment decisions and abide by the Student Health Services policies and procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan approved by Student Health Services.

**You will be charged \$20.00 for any appointment at SHS missed without notice.**

### **MATERNITY and NEWBORN CHILD BENEFITS:**

Student Health Services covers inpatient maternity care at Barnes-Jewish Hospital, Barnes Jewish West County Hospital, or Missouri Baptist Medical Center. Covered Persons must notify Student Health Services either three (3) business days prior for planned admissions or two (2) business days following emergency admissions. You are responsible for a \$500 copay for the first delivery and a \$1,000 copay for any additional deliveries. Student Health Services will pay 100% of the remaining covered expenses for up to 96 hours following a caesarean section delivery and up to 48 hours following any other delivery.

Student Health Services also covers all routine nursery care for newborn infant for up to 96 hours following a caesarean section delivery and for up to 48 hours following any other delivery. Newborn infant means any child birthed by a Student or Covered Dependent. The right to continue such coverage for the newborn infant beyond the first 48 or 96 hours is determined by the “Eligible Dependent” guidelines above. If the Student enrolls the Eligible Dependent within thirty one (31) days of the child’s birth, enrollment for the newborn will be retroactively effective back to the date of birth. If not, coverage will end after the initial 48 or 96 hour period.

To clarify: a newborn child of a Student’s Covered Child (the Student’s grandchild) is covered for the initial 48 to 96 hours, but is not eligible for continued coverage beyond that initial 48 or 96 hour period.

Preventive care benefits defined under the Health Resources and Services Administration (HRSA) requirement include the cost of renting or purchasing one breast pump per pregnancy in conjunction with childbirth. These benefits are only available if breastfeeding pump is obtained from Student Health Services while you are breastfeeding once every three years. You will not be reimbursed for supplies (unless pregnant again before you are eligible for a new pump), such as breast pumps, purchased at retail. If more than one type of breast pump can meet your needs, benefits are available only for the most cost effective standard electric breastfeeding pump (non-hospital-grade) as determined by Student Health Services. Student Health Services may determine that the pump should be rented rather than purchased. . Benefits are not covered out-of-network.

### **RECONSTRUCTION FROM MASTECTOMY**

Benefits will be paid the same as any other Sickness for a Mastectomy or reconstructive surgery necessary to restore symmetry incident to the Mastectomy when recommended by a Physician.

If a female beneficiary requires a mastectomy that is otherwise covered under the Plan and elects breast reconstruction in connection with such mastectomy, Student Health Services shall cover (1) all stages of reconstruction on the breast on which the mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (3) prostheses and physical

complications of mastectomy, including lymphedemas. Such treatment plan must be submitted to Student Health Services for approval prior to the mastectomy for coverage to qualify. "Mastectomy" means to removal of all or part of the breast for Medically Necessary response as determined by a Physician. Benefits are not covered out-of-network.

## **SEXUALLY TRANSMITTED DISEASE SERVICES**

Student Health Services provides sexually transmitted disease information, testing, and treatment, as well as confidential HIV testing. Benefits are not covered out-of-network.

## **TRANSGENDER SERVICES**

The Plan provides psychotherapy coverage for gender identity and associated co-morbid psychiatric diagnoses. The benefits are the same as any other outpatient mental health service.

- Student Assistance Program (SAP) provides all enrolled students and their immediate family members limited free of charge family therapy without referral.

Benefits include Medical Necessity treatment, persistent, well-documented gender dysphoria and when provided by an in-network provider.

- Hormone replacement therapy services appropriate to the individual's gender identity, i.e., hormones of the desired gender.
- Out-of-network benefits are not covered. Must have medical documentation showing patient has been properly assessed according to recognized medical practice, World Professional Association for Transgender Health Clarification Statement and Standards of care.

If the Covered Person is eligible for benefits, the benefits are provided the same as any other eligible drug as describe in this plan.

Laboratory testing to monitor the safety of continuous hormone therapy. If the Covered Person is eligible for benefits, the benefits are the same as any other outpatient diagnostic service on the plan.

Medically Necessary Surgical treatments (breast/chest/genital) for transformation reassignment/gender dysphoria can be initiated with a Student Health referral. The patient must meet all of the following eligibility criteria for genital surgery and surgery to change secondary sex characteristics. Benefits are payable only:

- Insured under the school's SHS for at least 12 consecutive months; and
- Has lived within the desired gender role full-time for at least 6 months (real life experience) without returning to the original gender and
- With one letter from professional providing gender affirming care. The diagnosis of Gender Dysphoria must be made by a licensed psychiatrist or psychologist; and
- The treatment plan must conform to the World Professional Association for Transgender Health Association (WPATH) standards (WPATH8)
- Surgery must be performed by a qualified In-Network provider. You and your physician must pre-certify the surgery with Student Health. If you do not, the surgery will not be covered.
- Benefits are not covered out-of-network.

- I. Female-to-Male:  
Initial mastectomy/breast reduction, hysterectomy, Salpingo-oophorectomy, Colpectomy, Vaginectomy, metoidioplasty, Scrotoplasty, urethroplasty, Phalloplasty, Placement of testicular prostheses.
- II. Male-to-Female:  
Orchiectomy, Penectomy, Vaginoplasty, Clitoroplasty, Labiaplasty, Colovginoplasty.

See non-covered benefits section below for elective sex transformation reassignment procedures exclusions.

## **OBESITY SURGERY**

Coverage for gastric bypass, gastric sleeve or lap band surgery requires pre-authorization by Student Health and requires the patient to satisfy all of the following specific criteria:

- Patient must be between the ages of 18-65;
- Patient must be at least 100 pounds over ideal weight and has a BMI of 40 or greater or BMI of 35 or greater with co-morbidity conditions including, but not limited to: Cardio-pulmonary problems, Cardio-vascular disease or hypertension, Congestive heart failure, Diabetes;
- Patient must be enrolled in and have participated in an organized weight loss program for a period of at least five years prior to surgery. The weight loss program does not have to be physician-directed;
- Patient must participate in a total assessment which includes: Behavioral assessment, Dietary assessment, Psychological assessment and Meetings with a Physical Therapist and Surgeon;
- Non-surgical methods of weight reduction must have been unsuccessfully attempted for at least five years under a Physician's supervision.
- Patient must be approved for this surgery by the attending physician based on the results of the total assessment; Pre-authorization from the health Plan is required for this surgery.

The member will pay the full amount of the total assessment. If the member is approved for the gastric bypass/gastric sleeve or lap band surgery, the plan will reimburse the member for a portion of the cost of the total assessment based on the office visit Copay. The plan will cover 80% of the in-network only hospitalization and surgery charges.. Other in-network related services will be subject to the Copay or coinsurance applicable to other covered medical services under the plan. Limited to 1 procedure per lifetime. Benefits are not covered out-of-network.

## **CLINICAL TRIALS**

Benefits are available for approved clinical trial routine patient care costs incurred during participation in a qualifying clinical trial for the prevention, detection or treatment associated with Phase I, II, III or IV cancer or other life-threatening disease or condition.

Experimental treatment and Services related to the Experimental treatment are covered when all of the following are met:

- Student Health Service considers the Experimental treatment to be conventional treatment when used to treat another condition (i.e., a condition other than what you are currently being treated for)
- The treatment is covered when it is provided as conventional treatment

- The Services related to the Experimental treatment are covered when they are related to conventional treatment.
- The Experimental treatment and related Services are provided during approved clinical trial (check with Student Health Service to determine whether a Clinical Trial is approved )
- A federally funded trial, as described in the Patient Protections and Affordable Care Act
- A trial conducted under an investigational new drug application reviewed by the FDA
- A drug trial that is exempt from having an investigational new drug application
- A study or investigation conducted by a federal department that meets the requirements of
- Section 2709 of the Patient Protection and Affordable Care Act

For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted. Benefits are available only when the covered person is clinically eligible for participation in the qualifying clinical trial as defined by the researcher. Benefits include the reasonable and necessary items and services used to prevent, diagnose, and treat complications arising from participation in a qualifying clinical trial.

Clinical Trials of experimental drugs or treatments proceed through four phases:

**Phase I:** Researchers test a new drug or treatment in a small group of people (20-80) for the first time to evaluate its safety, to determine a safe dosage range and to identify side effects. Phase I trials do not determine efficacy and may involve significant risks as these trials represent the initial use in human patients

**Phase II:** The study drug or treatment is given to a larger group of people (100-300) to see if it is effective and further evaluate its safety

**Phase III:** If a treatment has shown to be effective in Phase II, it is subjected to additional scrutiny in Phase III. In this phase, the sample size of the study population is increased to between 1,000 and 3,000 people. The goals in Phase III are to confirm the effectiveness noted in Phase II, monitor for side effects, compare the study treatment against current treatment protocols, and collect data that will facilitate safe use of the therapy or treatment under review

**Phase IV:** These studies are done after the drug or treatment has been marketed or the new treatment has become a standard component of patient care. These studies continue testing the study drug or treatment to collect information about their effect in various populations and any side effects associated with long-term use. Phase IV studies are required by the FDA when there are any remaining unanswered questions about a drug, device or treatment

**Experimental or Investigational** is a service that has not been scientifically demonstrated to be as safe and effective for treatment of the Member's condition as conventional or standard treatment in the United States

**Life-threatening Condition** means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted

Routine patient care costs for clinical trials do not include:

- The Experimental or Investigational Item, Device, or Service itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.
- Experimental treatment or Services related to Experimental treatment except as explained above

## EMERGENCY MEDICAL TRANSPORTATION

Coverage is provided for reasonable and customary emergency medical transportation charges. You will be responsible for paying coinsurance equal to twenty percent (20%) of the actual charge for the services of a professional ambulance to or from a hospital. Emergency Medical Transportation services are only covered when required due to the emergency nature of a covered accident or sickness. Ambulance service by air is covered in an Emergency if ground transportation is impossible, or would put your life or health in serious jeopardy.

The Plan also covers transportation provided by a licensed professional ambulance (either ground or air ambulance, as Student Health determines appropriate) between facilities when the transport is:

- to a Hospital that provides a higher level of care that was not available at the original Hospital;
- to a more cost-effective acute care facility; or
- from an acute facility to a sub-acute setting

## EMERGENCY and Urgnet SERVICES

Student Health Services provides coverage for emergency medical services to treat an emergency medical condition. Covered Persons should not go to an emergency room unless they are experiencing an emergency medical condition that requires emergency medical services.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (ii) serious impairment to bodily functions; or
- (iii) serious dysfunction of any bodily organ or part.

Emergency medical services means an initial medical screening examination and such further examination and treatment as are required to stabilize the patient. To stabilize means to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

When Student Health Services is open, Covered Adults are encouraged to go to Student Health Services for medical emergencies and Covered Children should go to Forest Park Pediatrics offices. If Student Health Services or Forest Park Pediatrics is closed Covered Persons are encouraged, but not required to, go to the Barnes-Jewish Hospital emergency room. Identify yourself as covered under the WUSM Student Health Services Program and show your Medical Benefits Card.

You must report all emergency room visits to Student Health Services within one business day of admission. **You will be responsible for charges incurred if you fail to comply with this notification requirement.** You will be required to pay a \$50 co-pay for medical emergency expenses. Student Health Services will pay covered expenses in excess of 80% of reasonable and customary charges and you will pay 20% co-insurance after the first \$200.00 of the covered expenses. You also will be asked to

assist in retrieving reports required from all medical care providers before bills can be processed for payment. Once the patient is stabilized, all other referral and approval requirements apply to any further medical care required because of the medical emergency. For example, once stabilized Students and Covered Dependents should seek care at Student Health Services or Forest Park Pediatrics, and fill any prescription through Student Health Services or the CAM as appropriate. Following notice of a medical emergency, Student Health Services will cover the reasonable and customary charges for follow-up services of a doctor (but only if away from Saint Louis or unable to visit Student Health Services), x-rays, lab tests, and up to four physical therapy visits within 90 days of the date of the emergency room visit if pre-approved by Student Health Services.

## **INPATIENT HOSPITALIZATION SERVICES**

Student Health Services provides coverage for hospitalizations if certified by Student Health Services. Generally, hospitalization should be at Barnes-Jewish Hospital, Barnes-Jewish West County Hospital, and Missouri Baptist Medical Center, or at Saint Louis Children's Hospital if a Covered Child. Professional care provided during hospitalization by Student Health Services staff, or in the case of a Covered Child, Forest Park Pediatrics, and other physicians within the Student Health Services In-Network and pre-approved through Student Health Services will also be covered.

If an inpatient stay is required, it is covered on a semi-private room basis. All inpatient admissions, including length of stay, must notify Student Health Services either three (3) business days prior for planned admissions or two (2) business days following emergency admissions. In the event of an emergency, you, your representative, your physician, or the hospital should telephone Student Health Services. Notification does not guarantee the payment of benefits for inpatient admission. Each claim is subject to eligibility, benefits, and medical necessity review and a review of adherence to notification guidelines in accordance with this booklet.

If you are hospitalized at an In-Network hospital (i.e., Barnes-Jewish Hospital, Barnes-Jewish West County Hospital, or Missouri Baptist Medical Center), you are responsible for a copayment of \$500 per hospital inpatient admission. Student Health Services will pay 100% of the remaining covered expenses.

If you are hospitalized at an Out-Network hospital, Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such expenses.

You must authorize your physician to send a copy of your Discharge Summary to Student Health Services before bills will be processed for payment.

Benefits also include private duty nursing services provided by a Registered Nurse or licensed practical nurse only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private duty nursing services includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Private duty nursing does not include Custodial Care Service.

## INPATIENT REHABILITATION SERVICES

Services received while confined as a full-time Inpatient in an in-network licensed Inpatient Rehabilitation Facility. Confinement in the Inpatient Rehabilitation Facility must follow within 24 hours of, and be for the same or related causes(s) as, a period of hospital confinement or Skilled Nursing Facility Confinement.

Benefits include a day rehabilitation therapy program for Insured's who do not require Inpatient care but still require rehabilitation therapy program four to eight hours a day at a Day Hospital. Day rehabilitation program services may consist of physical therapy, occupational therapy, speech therapy, nursing services and neuropsychological services. A minimum of two therapy services must be provided for the program to be a Covered Medical Expense.

If you are seen at an In-Network Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such expenses. Benefits are not covered out-of-network.

## HOME HEALTH CARE

Services received from a licensed in-network home health agency that is:

- Ordered by a Physician.
- Provided or supervised by a Registered Nurse in the Insured Person's home.
- Pursuant to a home health plan.
- 

Benefits also include private duty nursing services provided by a Registered Nurse or licensed practical nurse only when the services are of such a nature that they cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private duty nursing services includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Private duty nursing does not include Custodial Care Service.

If you are seen at an In-Network Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such expenses. Benefits are not covered out-of-network.

## SKILLED NURSING SERVICES

Services received while confined as a full-time Inpatient in an in-network skilled nursing facility for treatment rendered for one of the following:

- In lieu of Hospital Confinement as a full-time inpatient.

**If you are seen at an In-Network Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such expenses. Benefits are not covered out-of-network. HOSPICE CARE**

When recommended by a Physician for an Insured Person that is terminally ill with a life expectancy of six months or less. All hospice care must be received from an in-network licensed hospice agency.

- Physical, psychological, social and spiritual care for the terminally ill Insured.
- 
- Short-term grief counseling for immediate family members while the Insured is receiving hospice care and up to one year after the member's death

If you are seen at an In-Network Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such expenses. Benefits are not covered out-of-network.

Hospice care services do not include the following:

- Any curative or life prolonging procedures;
- Services of a close relative or individual who normally resides in the patient's home; and
- Any period when the individual receiving care is not under a physician's care.

## **TRANSPLANTATION SERVICES**

Inpatient facility services (including evaluation for transplant, organ procurement and donor searches) for transplantation procedures must be ordered by a provider. Benefits are available to the donor and the recipient when the recipient is covered under this Plan. The transplant must meet the definition of a Covered Health Service and cannot be Experimental or Investigational, or Unproven. Examples of transplants for which Benefits are available include but are not limited to:

- heart; heart/lung;
- lung; kidney;
- kidney/pancreas;
- liver; liver/kidney;
- liver/intestinal;
- pancreas;

## **THERAPEUTIC TREATMENTS - OUTPATIENT**

The Plan pays Benefits for therapeutic treatments received on an outpatient basis In –network Hospital or Alternate Facility or in a Physician's office, including dialysis (both hemodialysis and peritoneal dialysis), intravenous chemotherapy or other intravenous infusion therapy, and radiation oncology

Covered Health Services include medical education services that are provided on an outpatient basis at an in-network Hospital or Alternate Facility by appropriately licensed or registered healthcare professionals when:

- education is required for a disease in which patient self-management is an important component of treatment;
- and there exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

Benefits under this section include:

- the facility charge and the charge for related supplies and equipment;
- and Physician services for anesthesiologists, pathologists and radiologists.

## **TEMPOROMANDIBULAR JOINT (TMJ) SERVICES:**

The Plan covers diagnostic and surgical and non-surgical treatment of conditions affecting the temporomandibular joint when provided by or under the direction of a Physician.

Coverage includes necessary treatment required as a result of accident, trauma, a Congenital Anomaly, developmental defect, or pathology. Diagnostic treatment includes examination, radiographs and

applicable imaging studies and consultation. Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections. Coverage is not provided for any Orthodontic and prosthetics devices, including but not limited to braces or mouth guards.

Benefits are provided for surgical treatment if: there is clearly demonstrated radiographic evidence of significant joint abnormality;

- non-surgical treatment has failed to adequately resolve the symptoms;
- and pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

- Coverage for non-surgical treatment is limited to \$2,000 per covered person per lifetime.
- Coverage is limited to one surgical session per covered person per lifetime.

**If you are seen at an In-Network Student Health Services will pay 80% of the reasonable and customary covered expenses and you will be responsible for 20% of such expenses. Benefits are not covered out-of-network.**

## DENTAL CARE

Student Health Services provides coverage for accidental injury to the jaws, a sound natural tooth, mouth, or face provided care commences within 72 hours of the accident. Injury as a result of chewing or biting shall not be considered an accidental injury. Coverage for injury to a sound natural tooth is 100% of the first \$300 of expenses, and 80% of the balance, not to exceed \$1,000.00 as a result of any one accident. Student Health Services will provide a referral to a list of private dentists upon request. Refer to the Sun Life Financial certificate for details.

## VISION CARE

Student Health Services covers the cost of one routine eye exam/refraction office visit every two years through the Cohen Eye Associates. No referral is needed for this appointment (although you will be required to provide the Cohen Eye Associates with a voucher to proper billing). If you experience eye difficulty while enrolled and require more than one eye examination every two years, please contact Student Health Services for a referral. You will be responsible for a copayment of \$20.00 per visit.

- There is no Student Health Services coverage for contact lens fittings.

## PEDIATRIC VISION SERVICES

Student Health Services covers the cost of one routine eye exam/refraction office visit every years through the Barnes-Jewish Vision Center. No referral is needed for this appointment (although please provide the Vision Center with a referral form to ensure proper billing). You will be responsible for a copayment of \$20.00 per visit. Benefits are not covered out-of-network.

Student Health Services will pay 50% for one pair of prescription eyeglasses for covered children under the age of 19 per academic year. You will be responsible for 50% co-insurance. Examples of glass or plastic lenses for which Benefits are available include but are not limited to:

- single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses

- polycarbonate prescription lenses with scratch resistance coating and low vision items

In addition, benefits are available when an In-Network Vision Care Provider has determined a need for and has prescribed contact lenses. Contact lenses are necessary if the Covered Person has any of the following; Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism. Limited to a 12 month supply.

## **PEDIATRIC DENTAL SERVICES**

Benefits are provided for Covered Dental Services for Covered Persons under the age of 19. Benefits terminate on the earlier of: 1) date the Covered Person reaches the age of 19; or 2) date the Covered Person's coverage under the policy terminates.

Student Health will provide a Directory of Network Dental Providers available to the Covered Person. The Covered Person can also call Assurant Customer Service at 1-800-733-7879 or 314-362-2346 to determine which providers participate in the Network. The telephone number for Customer Service is also on the Covered Person's ID card.

Benefits are provided for Pediatric Dental Services stated in this section when such services are:

- Necessary
- Provided by or under the direction of an In-Network Dental Provider
- Clinical situations that can be effectively treated by a less costly, dental appropriate alternative procedure will be assigned a benefit based on the least costly procedure.

Benefits limits are calculated on an academic year basis unless otherwise specifically stated.

- Diagnostic Services;
  - Cephalometric X-ray.
  - Oral/Facial Photographic Images; and,
  - Diagnostic Models
- Preventive Services;
  - Fluoride Treatments Limited to 2 treatments per 12 months. Treatment should be done in conjunction with dental prophylaxis.
  - Topical Fluoride Varnish
  - Preventative resin restorations in a moderate to high caries risk patient (permanent tooth)
  - Sealants (Protective Coating) Limited to one sealant per tooth every 36 months.
  - Palliative treatment of dental pain – minor procedure.
- Minor Restorative Services, Endodontics, Periodontics and Oral Surgery;
  - Prefabricated stainless steel crown (permanent tooth). Limited to 1 per tooth in 60 months under the age of 15
- Major Restorative Services;
  - Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months;
  - Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months;
  - Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months; and,
  - Crown – titanium– Limited to 1 per tooth every 60 months
- Endodontic Services;
  - Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately;

- Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime; and,
- Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
- Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.);
- Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.);
- Apexification/recalcification - final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.); and,
- Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration.
- Periodontal Services;
  - Clinical crown lengthening-hard tissue;
  - Pedicle soft tissue graft procedure;
  - Free soft tissue graft procedure (including donor site surgery); and,
  - Subepithelial connective tissue graft procedures (including donor site surgery).
- Prosthodontic Services;
  - Replace missing or broken teeth - complete denture (each tooth);
  - Add clasp to existing partial denture;
  - Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation;
  - Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation; and,
  - Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation.
  - Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months;
  - Endosteal Implant - 1 every 60 months;
  - Surgical Placement of Interim Implant Body - 1 every 60 months;
  - Eposteal Implant – 1 every 60 months;
  - Transosteal Implant, Including Hardware – 1 every 60 months;
  - Implant supported complete denture;
  - Implant supported partial denture;
  - Connecting Bar – implant or abutment supported - 1 every 60 months;
  - Prefabricated Abutment – 1 every 60 months;
  - Abutment supported porcelain ceramic crown -1 every 60 months;
  - Abutment supported porcelain fused to high noble metal - 1 every 60 months;
  - Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months;
  - Abutment supported porcelain fused to noble metal crown - 1 every 60 months;
  - Abutment supported cast high noble metal crown - 1 every 60 months;
  - Abutment supported cast predominately base metal crown - 1 every 60 months;
  - Abutment supported cast noble metal crown - 1 every 60 months;
  - Implant supported porcelain/ceramic crown - 1 every 60 months;
  - Implant supported porcelain fused to high metal crown - 1 every 60 months;
  - Implant supported metal crown - 1 every 60 months;
  - Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months;
  - Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months;

- Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months;
- Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months;
- Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months;
- Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months;
- Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months;
- Implant supported retainer for ceramic fixed partial denture - 1 every 60 months;
- Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months;
- Implant supported retainer for cast metal fixed partial denture - 1 every 60 months;
- Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months;
- Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months;
- Implant Maintenance Procedures -1 every 60 months;
- Repair Implant Prosthesis -1 every 60 months;
- Replacement of Semi-Precision or Precision Attachment -1 every 60 months;
- Repair Implant Abutment -1 every 60 months;
- Implant Removal -1 every 60 months;
- Implant Index -1 every 60 months;
- Pontic – titanium – Limited to 1 every 60 months;
- Pontic - porcelain/ceramic – Limited to 1 every 60 months;
- Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months;
- Inlay – metallic – two surfaces – Limited to 1 every 60 months;
- Inlay – metallic – three or more surfaces - Limited to 1 every 60 months;
- Onlay – metallic – three surfaces - 1 every 60 months;
- Onlay – metallic – four or more surfaces -1 every 60 months;
- Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months;
- Crown - porcelain/ceramic -1 every 60 months;
- Crown - 3/4 cast predominately base metal - 1 every 60 months;
- Crown - 3/4 cast noble metal - 1 every 60 months;
- Crown - 3/4 porcelain/ceramic - 1 every 60 months;
- Oral Services;
  - Coronectomy - intentional partial tooth removal;
  - Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant;
  - Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant;
  - Removal of exostosis;
  - Suture of recent small wounds up to 5 cm; and,
  - Excision of pericoronal gingiva.
  - Core buildup for retainer, including any pins - 1 every 60 months; and,
- Medical Necessary Orthodontics;
  - Benefits for comprehensive approved orthodontic treatment, only in those instances that are related to an identifiable syndrome such as cleft lip and or palate, Crouzon's syndrome, Treacher - Collins syndrome, Pierre - Robin syndrome, hemi - facial atrophy, hemi facial hypertrophy; or other severe craniofacial deformities which result in a physically handicapping malocclusion as determined by the network dental consultants.

Benefits are not available for comprehensive orthodontic treatment for crowded dentitions (crooked teeth), excessive spacing between teeth, temporomandibular joint (TMJ) conditions and/or having horizontal/vertical (overjet/overbite) discrepancies.

Student Health Services will pay 50% In-Network benefits of the reasonable and customary covered pediatric expenses for covered children until age 19 per academic year. You will be responsible for 50% co-insurance of eligible pediatric dental expenses. Additional Dental coverage is provided under a separate plan administered by Sun Life, see certificate for details.

## AUTISM SPECTRUM DISORDERS TREATMENT

Benefits are provided for coverage for the diagnosis and treatment of Autism Spectrum Disorders for **Covered Children**. Coverage provided for Autism Spectrum Disorder is limited to Medically Necessary treatment that is ordered by the covered person's treating licensed Physician or licensed psychologist in accordance with a treatment plan. Benefits are not covered out-of-network.

## COCHLEAR IMPLANTS

Coverage is provided for cochlear implants when used to restore useful hearing for **Covered Children**. Limited to one cochlear implant surgical service per consecutive five-year period, with each covered surgical service. The maximum includes all pre-op services, surgery, and devices. All post-op services are paid the same as any other covered services under this Plan. You will be responsible for a 20% coinsurance payment. Benefits are not covered out-of-network.

## NONCOVERED BENEFITS

This Plan does not cover or provide the following benefits:

- Medical expenses that are covered or would be covered in the absence of Student Health Services coverage by any other valid and collectible insurance
- Expenses incurred for a treatment, service, or supply that is not Medically Necessary, is not as effective as other treatment, or because you require a different or lesser level of care, as determined by Student Health Services in its sole discretion (even if prescribed, recommended, or approved by your attending physician or dentist).
- Care received in an emergency that is not emergency care.
- Experimental or Investigational Services, including treatments, procedures, protocols, drugs, or devices as determined by Student Health Services in its sole discretion
- Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Benefits for Clinical Trials for Cancer Treatment.
- Services of a physical or occupational therapist, except as referred through Student Health Services
- Psychiatrist's services outside the scope of Student Health Services, except as approved by Student Health Services
- Refractions performed by an ophthalmologist, or vision care, except as referred through Student Health Services
- Fitting of, or problems associated with, the elective use of contact lenses
- Adult Eye glasses, contact lenses, and hearing aids,

- Osteopathy
- Health spa or similar facilities. Strengthening programs.
- Acupuncture, holistic medicine, aroma therapy, massage, and massage therapy,
- Routine foot care when there is not a localized illness, injury, or symptom involving the foot. Medications filled away from campus without prior approval by Student Health provider.
- Contraceptive medications, devices or methods that are not prescribed by a physician, and insertion of Norplant.
- Contraceptive devices, unless required to be covered in comprehensive guidelines supported by the Health Resources and Services Administration and approved by the Food and Drug Administration.
- Gardasil vaccine against human papillomavirus, if given before age 9 or after age 26
- Services of the type ordinarily performed by a dentist, or an oral surgeon, except for services to repair an injury to a sound natural tooth
- Vaccinations, immunizations, or medications required or recommended for travel. This exclusion does not apply to immunization that must be covered by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention for routine use in the United States (ACIP). Thus, for example, the following immunizations are not covered; Japanese Encephalitis, Polio (IPV) Adult Booster, Typhoid Oral Vaccine, Typhoid Vi Injectable and Yellow Fever.
- Immunization received outside of Student Health Service.
- Expenses incurred as a result of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route
- Expenses for injuries sustained as a result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits
- Expenses covered by any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage, or similar contract of insurance when such contract or insurance is issued to or makes benefits available to you regardless of whether a claim is made
- Expenses incurred for injury or sickness from declared or undeclared war of any act thereof
- Skydiving. Parachuting. Hang gliding. Glider flying. Parasailing. Sail planning.
- Expenses for artificial insemination, in vitro fertilization, or embryo transfer procedures, elective sterilization reversal, or elective abortion. Reversals of sterilization procedures such as vasectomies and tubal ligations, male elective sterilization;
- Infertility artificial reproduction procedures of any type, including but not limited to artificial insemination, in-vitro fertilization and related techniques, gamete intrafallopian tube transfer (GIFT), ovum transfer and embryo transfer, procreative counseling, genetic counseling and genetic testing, cryopreservation of reproductive materials. Storage of reproductive materials, fertility tests, infertility treatment (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, reversal of sterilization procedures, sexual reassignment surgery;
- Expenses incurred for gender affirming: no coverage for cosmetic procedures. Surgery to change specified secondary sex characteristics, specifically: thyroid chondroplasty (removal or reduction of the Adam's apple); and bilateral mastectomy; and augmentation mammoplasty (including breast prosthesis). In addition to the surgeon fees, this exclusion applies to the services related to the surgery including: anesthesia, pathology, hospital and facility fees, and surgical center fees.
- Expenses incurred for gender affirming treatments: reversal of genital surgery, sperm preservation in advance of hormone treatment, cryopreservation of fertilized embryos, voice modification surgery, suction-assisted lipoplasty of the waist, voice therapy.

- Long-Term/Custodial Nursing Home Care
- Ambulance services for trips to a physician's office or clinic, a morgue or a funeral home.
- Charges in excess of the Reasonable and Customary Charge
- Elective surgery or Cosmetic Surgery, except as Medically Necessary as a result of a birth defect, accidental injury or a malignant disease process or its treatment, or as a result of a mastectomy and in accordance with the Reconstruction from Mastectomy section.
- Expenses incurred for custodial care, defined as services and supplies furnished to a person mainly to help him or her in the activities of daily life, including without limitation room and board and other institutional care, regardless of who prescribes, recommends or performs them
- Participation in a riot or civil disorder: Commission of or attempt to commit a felony; (a) while engaged in any activity that constitutes a felony, (b) while performing any acts of violence of physical force that would not be performed by a reasonably prudent person in similar circumstances.
- Outpatient care other than through Student Health Services, other than follow-up care after emergency room or hospital care for Students, Spouses, and Domestic Partners, and other than at Forest Park Pediatrics for Covered Children
- Expenses incurred after the date Student Health Services coverage ends
- Consultations, diagnostic studies, or medications not specifically authorized by Student Health Service physicians for Students, Spouses, and Domestic Partners, and by Forest Park Pediatrics for Covered Children
- Genetic testing that does not meet preventive services criteria. Genetic testing for the sole purpose of determining the sex of a fetus. Genetic testing for non-Student Health Service Covered Persons.
- Bariatric Surgery, except as identified under Bariatric. . Not available for the Garren gastric bubble techniques relating to morbid obesity. This includes roux-en-Y (RNY), laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgeries that result in an inpatient stay or an extended inpatient stay for the bariatric surgery
- Inpatient Hospital/Physician Services oral surgery that is dental in origin; removal of impacted wisdom teeth, reversal of voluntary sterilization, radial keratotomy, keratoplasty, Lasik and other surgical procedures to correct refractive defects; surgeries for sexual dysfunction; surgeries or services for sexual transformation; surgical treatment of flat feet, subluxation of the foot, week strained, unstable feet, tarsalgia, metatarsalgia, hyperkeratosis, surgical treatment of gynecomastia; treatment of hyperhidrosis, elective abortions; sclerotherapy for treatment of varicose veins of the lower extremity; treatment of telangiectasia dermal veins.
- Transplant, health services for organ and tissue transplants, except as identified under Transplantation Services. Mechanical or animal organ transplants, except services related to the implant or removal or a circulatory assist device (a device that supports the heart while the patient waits for a suitable donor heart to become available), and donor costs for organ or tissue transplantation to another person.
- Wigs and artificial hair pieces or any drug-prescription or otherwise-used to treat baldness.

This list is not meant to be exclusive or exhaustive. All claims submissions will be reviewed on a case-by-case basis and a determination will be made according to the terms of this document.

## CLAIM SUBMISSIONS PROCEDURES

If you receive a medical bill, you should immediately bring a copy of the bill to Student Health Services. Some providers will submit their bills directly to Student Health Services. In either case, payment will be made directly to the provider. If you have already paid the bill, you will need to submit proof of payment in order to be reimbursed.

Bills should be brought or sent to:

Student Health Service, WUMS  
660 South Euclid Ave., Box 8030  
St. Louis, Missouri 63110  
Fax (314) 362-0058  
Telephone (314) 362-2346

All claim forms must be submitted within 12 months after the date of service.

### Expedited Benefit Determination Involving Urgent Care

In the case of urgent care claims, Student Health Services will notify you of a benefit determination (whether adverse or not) as soon as possible, but no longer than 24 hours after receipt of the claim, unless the claim fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable.

## RECOVERY OF OVERPAYMENT

If a benefit payment is made by Student Health Services to, or on behalf of, any covered person which exceeds the benefit amount such covered person is entitled to receive, in accordance with the terms of the group contract; Student Health Services has the right to:

- Require the return of the overpayment on request.
- Reduce, by the amount of the overpayment, any future benefit or payment made to or on behalf of the covered person or another person in his or her family.

Such right does not affect any other right to recovery Student Health Services may have with respect to such overpayment.

## OUT-OF-POCKET MAXIMUM

The annual Out-of-Pocket Maximum

Out-of-pocket maximum: In-network - \$3,500 per individual/\$ 12,700 per family per benefit year; Out-of-network - \$3,500 per individual/\$12,700 per family per benefit year. Separate out-of-pocket maximum amounts apply for in and out-of-network, they are not combined. 2021 the Out-of-Pocket Maximum is:

Individual	\$3,500
Family	\$12,700 (when two or more members are covered under on contract)

The annual Out-of-Pocket Maximum may be increased by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4) on an annual basis. Out-of-Pocket expenses for Essential

Health Benefits paid to other entities other than Student Health Services (e.g., for Pediatric Oral Care through the Assurant Dental coverage) must be reported to Student Health Services for a proper accounting—please maintain all records of health care expenditures to verify that you have reached the Out-of-Pocket Maximum.

There are no lifetime or annual limits on Essential Health Benefits that the Student or Covered Dependent may claim from Student Health Services. However, covered services that are Non-Essential Health Benefits are subject to a \$2,000,000 per person annual benefit limit on all benefits covered by Student Health Services. Once you have reached the annual benefit limit, you will be responsible for 100% of all Non-Essential Health Benefit's.

## RIGHT TO REVIEW AND APPEAL

### Right to Review

You have a right to review any decision we make to deny payment on your claim or your request for coverage of a health care service or treatment. You may request an explanation when your claim or request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered.

Contact us when you:

- Do not understand the reason for the denial;
- Do not understand why the health care service or treatment was not fully covered;
- Do not understand why a request for coverage of a health care service or treatment was denied;
- Cannot find the applicable provision in your Benefit Plan Document;
- Want a copy of the guideline, criteria or clinical rationale that we used to make our decision; or
- Disagree with the denial or the amount not covered and you want to appeal.

If your claim was denied due to missing or incomplete information, you or your health care provider may resubmit the claim to us with the necessary information to complete the claim.

### Right to Standard Internal Appeals

You have a right to request an internal appeal if the covered person disagrees with the decision Student Health denies payment, in whole or in part, of a claim or request for benefits. **Student Health Services will notify you at the time of a denial of your right to appeal.** All appeals for claim denials (or any decision that does not cover expenses you believe should have been covered) must be sent to Student Health Services within 180 days of the date you receive a notice of Adverse Determination or notice of an event that gives rise to a Grievance.. We will provide a full and fair review of your claim by individuals associated with us, but who were not involved in making the initial denial of your claim. You have the right to review the claim file free of charge and present evidence and testimony that relates to your claim. We will notify you of our decision regarding your appeal in writing within 60 days of receiving your request for appeal. If we deny your claim on appeal, or you do not receive our decision within 60 days, you are entitled to file a request for external review.

### Right to Expedited Internal Appeals

For Urgent Care Requests, a covered person may submit a request, either orally or in writing for an Expedited Internal Review (EIR). You, your doctor or someone acting on your behalf can initiate an expedited review by calling Student Health Service 314-362-3523 or faxing 314-362-0058. We will decide within 72 hours of receiving both your grievance and your physician's confirmation. If we tell you our decision verbally, we must also provide a written confirmation within two business days. If we

fail to provide you with our final determination timely or you receive an adverse determination, you may request an expedited external review from within 10-calendar days of receiving our final determination. In some instances, we may waive the requirement to exhaust our internal grievance process.

An Urgent Care Request means a request for services for treatment where the time period for completing a standard internal appeal:

- Could seriously jeopardize the life or health of the enrollee's person or jeopardize the enrollee's ability to regain maximum function; or
- Would, in the opinion of the Physician with knowledge of the enrollee's medical condition, subject to enrollee to severe pain that cannot be adequately managed without the requested health care service or treatment.

The covered person shall be notified orally of the EIR decision no more than seventy-two (72) hours after receipt of the EIR request.

To request an Expedited Internal Appeal, please contact Student Health at 314-362-3523. The written request for an expedited internal appeal should be sent to: Student Health Service, 660 S. Euclid, Box 8030, St. Louis, MO 63110.

The covered person or the Authorized Representative shall be notified orally of the EIR decision no more than seventy-two (72) hours after the receipt of the EIR request.

### **Right to External Independent Appeals**

You may file a grievance with ManagingCare, ManagingCost (MCMC) when the covered person has received an Adverse Determination. The enrollee may submit a request for an External Independent Review within 45 days after the IRO receives the request without exhausting all remedies available. The expedited internal appeal to be initiated at the same time as the external review. With respect to an expedited external review, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after IRO receives the request. The process is available at no charge to you.

You may request an external review of adverse benefit determinations based upon any of the following:

- Your claim was denied based on a medical judgment, for example that your treatment is not medically necessary, is not as effective as other treatments, or that you require a different or lesser level of care;
- Your claim was denied for an Experimental or Investigational Service; or
- As otherwise required by applicable law.

You or your representative may request a standard external review by sending a written request to the address set out in the determination letter. You or your representative may request an expedited external review (EER), in urgent situations as detailed below, by calling Student Health Services or by sending a written request to the address set out in the determination letter. Written notice of the final external review decision shall be provided by the IRO within 45 days after the IRO receives the standard request. As to an expedited review as expeditiously as the medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request.

In urgent care cases as expeditiously as possible after receipt of the request no later than 72 hours after the receipt of the EIR request. A request must be made within four months after the date you received Student Health Services decision.

An external review request should include all of the following:

- A specific request for an external review;
- The Covered Person's name, address, and insurance ID number;
- Your designated representative's name and address, when applicable;
- The service that was denied; and
- Any new, relevant information that was not provided during the internal appeal.

An external review decision will be binding on Student Health Services as well as you, except to the extent other remedies are available under State or Federal law.

### **Where to Send External Appeals**

All types of External requests/appeals shall be submitted to MCMC at the following address

MCMC LLC  
PO Box 809302  
Chicago, IL 60680

## **PRIVACY POLICY**

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic 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 nonpublic personal information.

## **REQUESTING A COPY OF YOUR MEDICAL RECORDS**

Student Health Service patients have a right to request a copy of his or her medical records. However, a completed written authorization is required prior to processing the request. You will be responsible for a reasonable, cost based fee that includes labor, supplies, and postage for handling all record requests. You will not be charged a fee for searching for or retrieving your records.

## **SUBROGATION AND REIMBURSEMENT**

The Plan has a right to subrogation and reimbursement.

Subrogation applies when the plan has paid benefits on your behalf for a sickness or injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is alleged to be responsible.

The right to reimbursement means that if a third party causes or is alleged to have caused a sickness or injury for which you receive a settlement, judgment, or other recovery from any third party, you must use those proceeds to fully return to the Plan 100% of any benefits you received for that sickness or injury – including the time and supplies provided by Student Health Services.

The following persons and entities are considered third parties:

- a person or entity alleged to have caused you to suffer a sickness, injury, or damages, or who is legally responsible for the sickness, injury, or damages;
- any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury, or damages;
- any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, other insurance carriers, or third party administrators; and
- any person or entity that is liable for payment to you on any equitable or legal liability theory.

You agree to cooperate with the Plan in protecting its legal and equitable rights to subrogation and reimbursement in a timely manner, including, but not limited to:

- notifying the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused benefits to be paid or become payable or service to be rendered by Student Health Services;
- providing any relevant information requested by the Plan;
- signing and/or delivering such documents as the Plan or its agents reasonably request to secure the subrogation and reimbursement claim;
- responding to requests for information about any accident or injuries;
- making court appearances;
- obtaining the WUSM's consent before releasing any party from liability or payment of medical expenses; and
- complying with the terms of this section.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, SHS's first priority right to payment is superior to any and all claims, debts, or liens asserted by any other medical providers, including but not limited to Hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party or insurance carrier.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent.

Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

The Plan's rights to recovery will not be reduced due to your own negligence.

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.

The provisions of this section apply to the parents, guardian, or other representative of a Covered Child who incurs a sickness or injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's sickness or injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

SHS has such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights, and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

## PATIENT RIGHTS AND RESPONSIBILITIES

Students eligible to receive care from the Washington University School of Medicine Student Health Services have the following rights and responsibilities:

- Right to competent, responsible, and respectful care by health providers who respect the full range of human diversity including race, color, age, religion, sex, sexual orientation, gender identity and expression, national origin, or disability.  
**Responsibility to act in a respectful manner towards SHS staff.**
- Right to be treated with dignity.  
**Responsibility to treat SHS staff with dignity.**
- Right to privacy during the time of your visit.  
**Responsibility to respect the privacy of other students you meet while at SHS.**
- Right to confidentiality of records. Right to approve or refuse release of your records to other healthcare providers, insurance companies, or other parties.  
**Responsibility to provide SHS with a written request for release of records at least one week in advance.**
- Right to be fully informed of diagnosis (to the degree known), treatment plan, and prognosis.  
**Responsibility to provide complete and honest information to your clinician so that together you can make the most effective decision about your care and clarify treatment options.**
- Right to ask about costs of services before accepting the services.  
**Responsibility to make arrangements for prompt payment of your bills, and to verify your insurance benefits for services recommended by and/or received from SHS.**
- Right to receive after hours consultation for urgent problems at SHS and if needed referral for care via hospital ER.  
**Responsibility to access SHS during normal working hours when full services are available.**
- Right to be informed of proposed participation in studies or experimental research.  
**Responsibility to gather as much information as possible before making decisions about participation in any study.**
- Right to change caregiver to any other appropriate caregiver at SHS.  
**Responsibility to address any concerns you have about your care with your current caregiver.**
- Right to evaluate care received at SHS.  
**Responsibility to contact SHS Director with any suggestions or concerns**

## GLOSSARY:

**Coinsurance:** form of medical cost sharing where the insured person pays a stated percentage of medical expenses after the deductible or copayment amount, if any, was paid.

**Copayment (or copay):** form of medical cost sharing where the insured person pays a fixed amount of medical expenses when medical services are received. SHS is responsible for the rest of reimbursement.

**Cosmetic Surgery:** procedures or services that change or improve appearance without significantly improving physiological function, as determined by Student Health Services. Reshaping a nose with a prominent bump is a good example of Cosmetic Surgery because appearance would be improved, but there would be no improvement in function like breathing.

**Cost Sharing:** cost sharing includes deductibles, coinsurance, copayments, and similar charges as well as any expenditure required by the Student or Covered Dependent which is a qualified medical expense within the meaning of section 223(d)(2) of the Internal Revenue Code with respect to essential health benefits under the plan. It does *not* include premiums, access fees, balance billing amounts for non-network providers, or spending on non-covered services.

**Covered Dependent:** an individual who meets the eligibility requirements specified in the Plan, as described under the *Eligibility* section above, who has enrolled only while enrolled and eligible for Benefits under the Plan.

**Covered Person:** either the Student or an enrolled Dependent only while enrolled and eligible for Benefits under the Plan. References to “you” and “your” throughout this Benefits Plan Description are references to a Covered Person.

**Deductible:** A fixed dollar amount during the benefit period that an insured person pays before the insurer starts to make payments for covered medical services. SHS does not have a deductible.

**Durable Medical Equipment (DME):** medical equipment that meets all of the following criteria:

- Used to serve a medical purpose with respect to treatment of a Sickness, Injury or their symptoms;
- Not disposable;
- Not of use to a person in the absence of a Sickness, Injury or their symptoms;
- Durable enough to withstand repeated use;
- Not implantable within the body; and
- Appropriate for use, and primarily used, within the home.

**Essential Health Benefits:** Essential Health Benefits include ambulatory patient services, emergency services, hospitalizations, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventative and wellness services and chronic disease management, pediatric services (including oral and vision care).

**Experimental or Investigational Item, Device, or Services:** medical, surgical, diagnostic, psychiatric, mental health, substance use disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time Student Health Services makes a determination regarding coverage in a particular case, are determined to be any of the following:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
- subject to review and approval by any institutional review board for the proposed use (Devices which are FDA approved under the Humanitarian Use Device exemption are not considered to be Experimental or Investigational);
- the subject of an ongoing Clinical Trial that meets the definition of a Phase I, II, or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or
- if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocols of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.
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Exceptions:

- Clinical trials for which benefits are available as described under Clinical Trials section.

If you are not a participant in a qualifying Clinical Trial as described under the Clinical Trial section and have a sickness or condition that is likely to cause death within one year of the request for treatment, Student Health Services may, at their discretion, consider an otherwise Experimental or Investigational Service to be a Covered Health Service for that sickness or condition. Prior to such consideration, Student Health Services must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

**Medically Necessary:** a service or supply that is, as determined by Student Health Service, necessary and appropriate for the diagnosis or treatment of a sickness or injury based on generally accepted current medical practice. A service or supply will not be considered as medically necessary if: (a) it is provided only as a convenience to the covered person or provider (b) it is not the appropriate treatment for the covered person's diagnosis or symptoms (c) it exceeds in scope, duration, or intensity that level of care which is needed to provide safe, adequate, and appropriate diagnosis or treatment. The facts that any particular physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary.

**Mental Health Services:** the diagnosis and treatment of mental health or psychiatric disorders, for example the diagnostic categories listed in the current *Diagnostic and Statistical Manual of the American Psychiatric Association* and not subject to a Non-covered Benefit.

**Network (or In-Network):** a term used to identify a selected group of providers how has coordinated with Student Health Services to provide care at a negotiated price.

**Out-Network:** a term used to identify the providers that Student Health Services does not (1) routinely work with or (2) does not have an arrangement for providing care at a negotiated price.

**Out-of-Pocket Maximum:** The most you pay in Cost Sharing each calendar year for Essential Health Benefits.

**Pregnancy:** includes prenatal care, postnatal care, childbirth, and any complications associated with Pregnancy.

**Provider:** an entity or individual who provides health care services, including but not limited to a doctor, nurse, hospital, clinic, or lab.

**Reasonable and Customary Charges:** the charges which are the smallest of: (a) the actual charge, (b) the charge usually made for a covered service by the provider that furnishes it, and (c) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

**Specialist:** a provider who specializes in a particular field of medicine who may be able to provide more targeted care due to their specialized knowledge.

**University:** The Washington University.

**EFFECTIVE DATE AND SIGNATURES**

The effective date of this Plan Document is July 1, 2022. Washington University School of Medicine agrees that the provisions contained in this Plan Document are acceptable and will be the basis for the Administration of said Plan described herein.

SIGNED AT \_\_\_\_\_

This July \_\_\_\_\_ day of 01, 2022

ATTEST: \_\_\_\_\_ By: \_\_\_\_\_