



WSC INSURANCE



SDHN0057501A-11

2011-2012



Student Health Insurance Plan

Underwritten by:

ACE American Insurance Company
Philadelphia, PA

Please read the brochure to understand your coverage.

SDHN0057501A-0311

Eligibility

Domestic Students

All registered students enrolled in one (1) or more credit hours are required to participate in the Student Health Insurance Plan. **The premium is automatically billed on the tuition billing statement unless proof of comparable coverage is provided by completing the online waiver by the August 13, 2011 deadline date for approval.** If it is found later that you do not meet the plan eligibility, the premium will be refunded and eligibility denied. Annual Coverage Period 8/15/11 through 8/14/12.

International Students

All International students and scholars registered/enrolled with VISA status (F-1, J-1 or M-1) who have not been granted permanent residency are required to be insured under this plan. Premium is charged to the tuition billing statement. Waiver may only be granted to international students in one of the following categories: (1) students who have government-provided insurance, which includes insurance provided through foreign embassies in the United States, (2) students who have insurance as a benefit of the employment of their immediate family member by a company in the United States, or (3) students from an official Pacific University exchange partner institution or recruitment agency who have insurance that meets all federal requirements for J-1 visa holders. The International Student Waiver Form must be completed and returned at least 5 days prior to the start of their academic term. Annual Coverage Period 8/15/11 through 8/14/12.

Physician Assistants Program, and Masters of Arts in Teaching Program

All registered students enrolled in one (1) or more credit hours are required to participate in the Student Health Insurance Plan. **The premium is automatically billed on the tuition billing statement unless proof of comparable coverage is provided by completing the online waiver two weeks prior to the start of their academic term for approval.** Physician Assistants Program Annual Coverage Period 5/10/11 through 5/09/12; Forest Grove/Woodburn Masters of Arts in Teaching Fifth Year Program Annual Coverage Period 06/12/11 through 06/22/12; and Lane County Masters of Arts in Teaching Fifth Year Program Annual Coverage Period 01/01/12 through 12/31/12.

Former Insured Students

Former insured students and covered dependents that were previously insured for six (6) consecutive months under this plan, may elect to continue their coverage for a period of three (3) or six (6) months provided there is no lapse in coverage and the required premium is received prior to their termination date of coverage under this plan. Once the Continuation Plan is purchased, it may not be renewed for an additional term. Premium rates for the continued coverage are higher than rates under this plan. Application must be made and applicable premium must be paid directly to Academic HealthPlans and be received prior to the expiration date of your 2010-2011 student coverage. For further information on this coverage, please contact Academic HealthPlans at (855) AHP-CARE.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, internet classes (except for MFA students), and television (TV) courses do not fulfill the Eligibility requirements that the student actively attend classes. The Company maintains its right to investigate student status and attendance records to verify that the Policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is refund of premium.

Eligible students may also insure their Dependents and Domestic Partners. Enrollment must take place at the initial time of student enrollment or beginning with the next enrollment period, with the exception of newborn or adopted children.

Dependent means an Insured's lawful spouse; Domestic Partner or an Insured's unmarried child, from the moment of birth to age 19, who is chiefly dependent on the student for support. Insurance will continue for any Dependent child who reaches the age limit and is unable to engage in any substantial gainful activity because of a mental or physical handicap that is expected to result in death or continued disability for at least 12 months. The student must send the Company satisfactory proof of the handicap within 31 days of the child reaching the maximum age for insurance to continue.

A child, for eligibility purposes, includes an Insured Student's: natural child; stepchild; adopted child, beginning with any waiting period pending finalization of the child's adoption. Dependent eligibility expires concurrently with that of the Insured Student.

A newborn child will automatically be covered for the first 31 days following the child's birth. To extend coverage for a newborn child past the first 31-day period, the covered student must: 1) enroll the child within 31 days of birth, and 2) pay any required additional premium, starting from the date of birth.

"Domestic Partner" means a person of the same or opposite sex of the Insured who: 1) shares his or her primary residence; 2) has resided with him or her for at least 24 months prior to the date of enrollment and is expected to reside with him or her indefinitely; 3) is financially interdependent with the Insured in each of the following ways; (a) by holding one or more credit or bank accounts, including a checking account, as joint owners; (b) by owning or leasing their permanent residence as joint tenants; (c) by naming, or being named by the other as a beneficiary of life insurance or under a will; (d) by each agreeing in writing to assume financial responsibility for the welfare of the other; 4) has signed a Domestic Partner declaration with him or her, if recognized by the laws of the state in which he or she resides; 5) has not signed a Domestic Partner declaration with any other person within the last 24 months; 6) Is older than 21 years old; 7) Is not currently married to another person; 8) Is not in a position as a blood relative that would prohibit marriage.

Proof of partnership must be provided to Academic HealthPlans along with the enrollment form based upon the criteria mentioned in the definition of Domestic Partner above.

Qualifying Event: Eligible students who have a change in status and lose coverage under another Health Care Plan are eligible to enroll for coverage under the Policy provided, within 31 days of the qualifying event; students send a copy of the Certificate of Creditable Coverage, the completed Qualifying Events Form and the letter of ineligibility to Academic HealthPlans. A change in status due to a qualifying event includes, but is not limited to, loss of a spouse, whether by death, divorce, annulment or legal separation. The premium will be the same as it would have been at the beginning of the semester or quarter, whichever applies. However, the effective date will be the later of the date the student enrolls for coverage under the Policy and pays the required premium, or the day after the prior coverage ends. You may download a form from www.ahpcare.com/pacificu.

You are entitled to the benefits described in this brochure, if you have enrolled for this insurance and paid the premium.

Alternative Coverage

If you do not meet the eligibility requirements of the plan, please call WSC Insurance at (503) 357-3154 *prior to your termination date* for information on alternative insurance plans.

Effective And Termination Dates

Coverage for the Covered Person becomes effective at 12:00 a.m. at the University's address on the later of:

- 1) The effective date of the Policy; or
- 2) The date premium is received by the Company or its authorized representative.

	From	Through
Domestic and International Students	08/15/11	08/14/12

The coverage provided with respect to the Covered Person shall terminate at 11:59 p.m. on the earliest of the following dates:

- 1) The last day of the period through which the premium is paid;
- 2) The date the eligibility requirements are not met; and
- 3) The date the Covered Person enters full time active duty in any Armed Forces.

Exceptions to the above given dates are:

	From	Through
Physician's Assistant Program	05/10/11	05/09/12
Forest Grove Masters of Arts in Teaching Program	06/20/11	06/19/12
Lane County Masters of Arts in Teaching Program	01/01/12	12/31/12

You must meet the eligibility requirements listed herein each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. It is the Student's responsibility to make timely renewal payments to avoid a lapse in coverage.

The Covered Person is insured worldwide based on the terms, conditions, benefits and exclusions of the Policy.

Once coverage has become effective and the student has met the 31 day eligibility requirement, the Company will only refund premium upon entry into the Armed Forces and the Company receives proof of active duty. Otherwise, all premiums received by the Company will be considered fully earned and non-refundable.

The Policy issued to the University is a Non-Renewable, One Year Term Policy. It is the Covered Person's responsibility to enroll for coverage each year in order to maintain continuity of coverage.

Extension of Benefits

The coverage provided under the Plan ceases on the termination date. However, if a Covered Person is hospital confined on the termination date for a Covered Injury or Sickness for which benefits were paid before the termination date, Covered Expenses for such Covered Injury or Sickness will continue to be paid provided the condition continues but not to exceed the earlier of 90 days after termination date or discharge from a Hospital.

The total payments made in respect of the Covered Person for such condition both before and after the termination date will never exceed the maximum benefit. After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Coordination of Benefits

If a Covered Person is eligible for benefits under this insurance Plan and any other group or blanket Plans, the Company will coordinate the benefits payable under this Plan with the benefits payable under the other group or blanket Plans.

Preferred Provider Information

Preferred Providers allow the Covered Person to maximize the benefits offered under this Plan. You should seek treatment from the Preferred Provider Organization (PPO), which consists of Hospitals, Doctors, ancillary, and other health care providers organized into a network for the purpose of delivering quality health care at affordable rates.

Your Preferred Provider Organization inside Oregon is Providence Preferred network and outside of Oregon is First Health network. For a list of providers go to www.ahpcare.com/pacificu (*Find a Doctor or Hospital link under Benefits*) or you may call (503) 574-7600 or (800) 793-9338 for Providence Preferred network and (800) 226-5116 for First Health network.

Maternity Testing

The following maternity routine tests and screening exams will be considered, if all other policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One Ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can be considered if a claim is submitted with the Pregnancy Record and Ultrasound report that establishes Medical Necessity. Additionally, the following tests will be considered for women over 35 years of age: AFP Blood Screening; Amniocentesis/ AFP Screening; and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. Prenatal vitamins are not covered. For additional information regarding Maternity Testing, please call Klais & Company (800) 331-1096.

Additional Covered Expense

The Company will pay benefits for the following mandated benefits. A detail of benefits for: Mammograms; Pap Smears and Pelvic Exams; Contraceptive Services and Nonprescription elemental enteral formula for home use, may be found in the Policy on file at the University.

Schedule of Basic Medical Expense Benefits - Injury and Sickness

\$100 Deductible Per Covered Person (per Policy term)

(Waived for treatment at the Student Health Center.)

Up to \$100,000 Basic Lifetime Maximum Benefit (per Injury or Sickness)

Paid as specified below

After the Deductible has been satisfied, benefits will be paid at 80% of the Preferred Allowance for services rendered by Preferred Providers in the Providence Preferred Network or First Health outside Providence Preferred Network area. Services obtained from Out-of-Network providers (any provider outside of Providence Preferred or First Health Networks) will be paid at 60% of Usual and Customary Charges. The Plan provides benefits for Covered Expenses incurred by a Covered Person for loss due to a Covered Injury or Sickness up to the Basic Lifetime Maximum Benefit of \$100,000, regardless of the provider selected. Benefits will be paid up to the Maximum Benefit for each service as specified below. Unless otherwise specified, the Maximum amounts specified below apply on a per Covered Injury/Sickness basis.

Note: The following Immunization/Vaccines will be covered at the Student Health Center: MMR (\$60 per Injection), Tdap (\$50-one dose required), Hep A (\$75 per injection-two doses in the series), Hep B (\$65 per injection-three doses in the series), Hep A-B (\$115 per injection-three doses in the series), PPD (\$25-TB skin test once per year), Titers (Measles, Mumps, Rubella, Hep B and Varicella-\$50 per test). The immunization/vaccine benefits are available to students at the regional campuses that do not have access to the Student Health Center.

If a Covered Person is traveling outside of the United States and requires medical treatment, benefits will be paid up to the benefit maximums and co-insurance rates that apply to In-Network benefits, subject to the Usual & Customary Charges incurred for such treatment. Covered Expenses are:

INPATIENT	In-Network	Out-of-Network
Hospital Expenses , daily semi-private room rate; general nursing care provided by the Hospital; Hospital Miscellaneous Expenses such as the cost of the operating room, pre-admission testing, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.	100% of Preferred Allowance/ \$2,250 aggregate maximum per day	80% of Usual & Customary Charges/ \$1,000 aggregate maximum per day
Intensive Care/Hospital Expense, \$2,500 aggregate maximum per day	100% of Preferred Allowance	80% of Usual & Customary Charges
Physical Therapy	Paid under Hospital Expenses	Paid under Hospital Expenses
Surgery , when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure. The surgical procedure with the highest allowable should be priced at 100% of allowance and the remaining eligible procedures should be priced at 50% of the allowable.	80% of Preferred Allowance	60% of Usual & Customary Charges
Assistant Surgeon , only when required by the Hospital.	80% of Preferred Allowance	60% of Usual & Customary Charges
Anesthetist	80% of Preferred Allowance	60% of Usual & Customary Charges
Registered Nurse , private duty nursing care.	80% of Preferred Allowance	60% of Usual & Customary Charges
Doctor's Visits	80% of Preferred Allowance	60% of Usual & Customary Charges
Mental/Nervous Disorder and Substance/Drug Abuse, 10 day maximum (per Policy term) , Psychiatric hospitals are not covered.	80% of Preferred Allowance	60% of Usual & Customary Charges

OUTPATIENT	In-Network	Out-of-Network
Surgery , when multiple surgical procedures are performed during the same operative session, the primary or major procedure is eligible for full allowance for that procedure. The surgical procedure with the highest allowable should be priced at 100% of allowance and the remaining eligible procedures should be priced at 50% of the allowable.	80% of Preferred Allowance	60% of Usual & Customary Charges
Day Surgery Miscellaneous , related to scheduled surgery performed in a Hospital, including the cost of the operating room laboratory tests, X-ray examinations, including professional fees, anesthesia, drugs or medicines and supplies.	80% of Preferred Allowance/ \$3,000 maximum	60% of Usual & Customary Charges/ \$1,000 maximum
Assistant Surgeon , only when required by the Hospital.	80% of Preferred Allowance	60% of Usual & Customary Charges
Anesthetist	80% of Preferred Allowance	60% of Usual & Customary Charges
Doctor's Visits	80% of Preferred Allowance	60% of Usual & Customary Charges
Physical Therapy , benefits are limited to one visit per day.	80% of Preferred Allowance	60% of Usual & Customary Charges
Medical Emergency, \$50 copay per visit , benefits are payable for the use of the Emergency Room & Supplies. (Treatment must be rendered within 72 hours of Injury or first onset of Sickness.) Benefits will be paid at 80% of Usual and Customary Charges if emergency treatment cannot be reasonably obtained from a Preferred Provider.	80% of Preferred Allowance	60% of Usual & Customary Charges
X-rays & Laboratory	80% of Preferred Allowance	60% of Usual & Customary Charges
Tests & Procedures , diagnostic services and medical procedures performed by a Doctor, other than Doctor's Visits, Physical Therapy, X-rays and Laboratory procedures.	80% of Preferred Allowance	60% of Usual & Customary Charges
Radiation Therapy	80% of Preferred Allowance	60% of Usual & Customary Charges
Injections , when administered in the Doctor's office and charged on the Doctor statement.	80% of Preferred Allowance	60% of Usual & Customary Charges
Prescription Drugs, \$2,000 maximum (per Policy term) and limited to a 30 day supply per prescription. Students who are traveling for clinical work or on vacation will not be limited to the 30 day prescription drug supply maximum. (See the Outpatient Prescriptions Drug section for additional information.) Includes contraceptives. \$100 per Policy term Deductible does apply.	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Mental/Nervous Disorder and Substance/Drug Abuse, \$2,500 maximum , including psychiatric and psychological care. Benefits are limited to one visit per day.	80% of Preferred Allowance	50% of Usual & Customary Charges
Severe Nodular or Cystic Acne	80% of Preferred Allowance	60% of Usual & Customary Charges

OTHER	In-Network	Out-of-Network
Ambulance, \$500 maximum	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Braces & Appliances, \$250 maximum , written prescription must accompany the claims.	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Dental, \$250 maximum , made necessary by Injury to Sound, Natural Teeth only.	80% of Usual & Customary Charges	80% of Usual & Customary Charges
Consultant, \$100 maximum , when requested and approved by the attending Doctor.	80% of Preferred Allowance	80% of Usual & Customary Charges
Maternity/Maternity Testing/Complications of Pregnancy , prenatal vitamins are not covered.	Paid as any other covered Sickness	Paid as any other covered Sickness

Routine Newborn Baby Care, \$750 maximum , well baby nursery care.	100% of Preferred Allowance	80% of Usual & Customary Charges
Contraceptive Services , includes outpatient consults, examination, procedures and medical services that are necessary to prescribe, dispense, deliver, distribute, administer or remove a prescription contraceptive device.	Paid as any other covered Sickness	Paid as any other covered Sickness
Therapeutic Abortion, \$500 maximum	80% or Preferred Allowance	60% of Usual & Customary Charges
Intercollegiate Sports, \$300 maximum	Paid as any other covered Injury	Paid as any other covered Injury
Bloodborne Pathogen Exposure, \$1,000 maximum	Paid as any other covered Injury	Paid as any other covered Injury
Services, supplies, or other Covered Expenses not specified above, but included in Mandated Benefits. (Subject to state mandated limitations and any limitations shown above.)	80% or Preferred Allowance	60% of Usual & Customary Charges

Outpatient Prescription Drug Benefit

Outpatient prescription drugs are provided through a prescription drug program managed by WellDyneRx. Covered Expenses are subject to the \$100 per Policy term Plan Deductible up to a maximum of \$2,000 per Policy term. After you have reached your maximum in Prescription Drug benefits, you can continue to use your ID Card and receive discounted prices for your prescriptions. In order to access this program and receive discounted prices for your Prescription Drugs, you must present your insurance ID Card to the pharmacy to identify yourself as a participant in this Plan. Once your prescription is filled, you will be required to pay for your prescription and then file your claim for reimbursement with Klais & Company, Inc. You can locate a WellDyneRx participating pharmacy by calling (888) 479-2000 or visit the website at www.ahpcare.com/pacificu (*Find a Pharmacy link under Benefits*).

Optional Major Medical Benefit

\$200,000 Lifetime Maximum Benefit (For Each Injury or Sickness)

Available only at the initial time of enrollment, provided the additional premium is paid. Optional Major Medical Benefit begins payment after the Basic Maximum Benefit of \$100,000 has been paid by the Company. The Company will pay 80% of Covered Expenses incurred up to the Major Medical Lifetime Maximum of \$100,000. The total benefits payable for any one Injury or Sickness under the Major Medical Lifetime Maximum Benefit is \$200,000 minus the \$100,000 paid under the Basic Benefit. No Benefits will be paid for Room & Board expenses which exceed the semi-private room rate. **NOTE:** The optional Major Medical Lifetime Benefit is an additional \$100,000 Lifetime Maximum. Once the \$100,000 Basic Maximum Benefit is combined with the \$100,000 Major Medical Lifetime Maximum, the student will have a total of \$200,000 Lifetime Maximum Benefit. The Major Medical benefit may only be purchased simultaneously and in conjunction with the purchase of Basic Coverage at the time of initial enrollment in the Plan. Please refer to the enrollment form for premium and enrollment information. **Dependents/Domestic Partners may be covered under this coverage only if the student purchases this coverage for him/herself. Coverage must be the same for all Covered Persons.**

Definitions

Covered Expenses means: expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies covered by this Policy. Covered Expenses are those expenses set forth in the Description of Coverage payable in the amounts specified in the Schedule of Benefits provided they are not excluded under this Policy. Coverage under the Policy must remain continuously in force from the date of the Accident or Sickness until the date treatment; services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained. Covered Expenses do not include any amount required to satisfy the Deductible, if any, or any amount in excess of the Usual and Customary Charge or benefit maximums.

Covered Person means: any eligible person or an eligible dependent who applies for coverage, and for whom the required premium is paid to Us.

Doctor means: a licensed health care provider including a clinical social worker, a duly licensed and certified nurse practitioner, a physician's assistant, chiropractor, a dentist, and an optometrist acting within the scope of his or her license and rendering care or treatment to a Covered Person that is appropriate for the conditions and locality. It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

Injury means: accidental bodily harm sustained by a Covered Person that results directly and independently from all other causes from a Covered Accident. The Injury must be caused solely through external, violent and accidental means. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

Medically Necessary means: a treatment, service or supply that is: 1) required to treat an Injury or Sickness; 2) prescribed or ordered by a Doctor or furnished by a Hospital; 3) performed in the least costly setting required by the Covered Person's condition; and 4) consistent with the medical and surgical practices prevailing in the area for treatment of the condition at the time rendered. A service or supply may not be Medically Necessary if a less intensive or more appropriate diagnostic or treatment alternative could have been used. We may consider the cost of the alternative to be the Covered Expense.

Out-of-Network means: a provider who has not agreed to any prearranged fee schedules. We will not pay charges in excess of the Usual and Customary Charges.

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

Preferred Provider means: the Doctors, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

Sickness means: an illness, disease or condition that causes a loss for which a Covered Person incurs medical expenses while covered under this Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

Usual and Customary Charge means: the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

Creditable Coverage

Your coverage under this health plan is "creditable coverage" under Federal Law. When your coverage terminates, you can request a Certificate of Creditable Coverage, which is evidence of your coverage under this plan. You may need such a certificate if you become covered under a group health plan or other health plan within 63 days after your coverage under this health plan terminates. A Certificate of Creditable Coverage may be requested in writing from Academic HealthPlans.

Pre-existing Condition Limitation

Benefits will not be paid for a pre-existing condition for which a Covered Person received medical treatment, care, diagnosis, or advice within (6) six consecutive months prior to the effective date of his or her coverage. This limitation will not apply if the Covered Person has not received such treatment, care, or advice within (6) six consecutive months while covered by this Policy, or if the Covered Person has been covered by this Policy for more than (6) six consecutive months. Medical treatment includes, but is not limited to, prescription medication.

A new (6) six month pre-existing condition limitation cannot be imposed in subsequent school years after the first, unless there is a separation period of more than one school term or semester break.

Continuous coverage will be granted from year to year; provided, any previous coverage was continuous to a date not more than one school term or semester break prior to the effective date of the new coverage. This coverage will be afforded to Covered Person's insured by any previous insurance plan provided this continuous coverage stipulation is met. If this continuous coverage stipulation is not met, any pre-existing condition excluded under this provision shall not qualify for coverage under this Student Health Insurance Program until (6) six months from the effective date of coverage.

Exclusions and Limitations

No benefits will be paid for any loss or expense caused by, contributed to, or resulting from:

1. Dental treatment, except for accidental Injury to sound, natural teeth;
2. Hearing examinations or hearing aids; or other treatment for hearing anomalies and problems. "Hearing anomalies " means any physical defect of the ear that can impair normal hearing, apart from the disease process;
3. Eyeglasses, contact lenses, prescriptions or examinations therefore. Radial Keratotomy/Lasik surgery is not covered;
4. Elective Surgery and Elective Treatment; (includes but is not limited to surgery and/or treatment for acne, except as specifically provided in the Policy; acupuncture; allergy testing; alopecia; biofeedback-type services; breast implants, breast reduction; circumcision; corns, calluses and bunions; cosmetic procedures, except when required to correct 1) an Injury for which benefits are otherwise payable under this policy; or 2) medically diagnosed congenital defects and birth abnormalities of a Newborn Infant; deviated nasal septum, including submucosa resection and/or other surgical correction thereof; family planning; fertility tests; impotence, organic or otherwise; infertility, (male or female,) including any services or supplies rendered for the purpose or with the intent of inducing conception; hirsutism; learning disabilities; obesity and any condition resulting therefrom; premarital examinations; preventative medicines or vaccines, except where required for the treatment of a covered Injury, except as specifically provided in the Policy; sexual reassignment surgery; skeletal irregularities of one or both jaws, including orthognathia and, mandibular retrognathia; temporomandibular joint dysfunction; tubal ligation; vasectomy; and weight reduction. Elective surgery and elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States;
5. Preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness;
6. Cosmetic procedures, except reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, and as required after a mastectomy, or for newborn or adopted children;
7. Services provided without charge by the Student Health Center, or services covered or provided by a student health fee;
8. Sleep disorders, supplies, treatment or testing relating to sleep disorders;

9. Injury sustained while (a) participating in any intercollegiate (in excess of \$300) or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
10. Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
11. Participation in a riot or civil disorder; commission of or attempt to commit a felony or illegal act;
12. An accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
13. War or any act of war, whether declared or not; and
14. Service in the military, naval or air service of any country.

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.

Academic Emergency Services

Students enrolled in the Student Health Insurance Plan can call the multilingual call center 24 hours a day, 365 days a year to confirm coverage and access available services. Services are available to students traveling more than 100 miles from their home or outside of their home country.

In addition to the insurance protection provided by your insurance plan, Academic HealthPlans has arranged to provide you with a \$10,000 Accidental Death and Dismemberment benefit and access to travel assistance services anywhere in the world. These services include:

- **Medical Assistance** including referral to a doctor or medical specialist, medical monitoring when you are hospitalized, emergency medical evacuation to an adequate facility, medically necessary repatriation, and return of mortal remains.
- **Personal Assistance** including pre-trip medical referral information and while you are on a trip: emergency medication, embassy and consular information, lost document assistance, emergency message transmission, emergency cash advance, emergency referral to a lawyer, translator or interpreter access, medical benefits verification and medical claims assistance.
- **Travel Assistance** including emergency travel arrangements and arrangements for the return of your traveling companion or dependents.
- **Security Assistance** including access to a secure, web-based system for tracking global threats and health or location based risk intelligence, and at an additional cost, a crisis hotline and on the ground security assistance to help address safety concerns or to secure immediate assistance while traveling outside of the country.

In the event of a medical emergency call Academic Emergency Services immediately

1-800-625-8833 toll free in the USA or Canada

1-240-330-1470 collect outside of the USA

This information provides you with a brief outline of the services available to you. Accident insurance is underwritten by ACE American Insurance Company on Form # AH-10324. Reimbursement for any service expenses is limited to the terms and conditions of the accident policy under which you are insured. You may be required to pay for services not covered under the policy.

CareNet 24-Hour Nurse Advice Line

The CareNet 24/7 Nurse Advice Line provides a convenient, easy, and confidential way to get medical care advice. RNs are available to help answer questions concerning a diagnosis or medical treatment, to assist with healthcare questions and to help you figure out the best course of action for a non-emergency health concern: Do you need immediate medical care? Should you see your provider? Or will self-care help you? With this service, you have round-the-clock access to experienced healthcare professionals that are ready to assist! CareNet Nurse Advice line (877) 924-7758. (*CareNet 24-hour Nurse Advice Line is not affiliated with ACE American Insurance Company.*)

Claim Procedure

In the event of Injury or Sickness, the Student should:

- 1) Contact the University Health Center at (503) 352-2269 for an appointment; or when not in school, a Doctor or hospital.

**IN AN EMERGENCY, REPORT DIRECTLY TO THE
NEAREST EMERGENCY ROOM FOR TREATMENT.**

- 2) Mail to the address below all medical and hospital bills along with patient's name, Insured student's name, address, ID number and name of the University under which the student is Insured. A medical claim form is no longer required for filing a claim. Prescription claim forms are available by calling Academic HealthPlans at (855) AHP-CARE or may be downloaded online at www.AHPCare.com/pacificu.
- 3) File claims within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service or soon as reasonably possible. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Submit Claims & Inquiries to:

Klais & Company, Inc.
1867 West Market Street
Akron, Ohio 44313
(EDI # 34145)

Medical Providers Call: (800) 331-1096

All Other Calls: (855) AHP-CARE

Email: KlaisClaims@Klais.com



Plan Administrator

Academic HealthPlans, Inc.
P.O. Box 1605
Colleyville, Texas 76034-1605
(855) 247-2273
(817) 479-2100
fax (817) 479-2101
www.AcademicHealthPlans.com

Local Agent



Waltz Sheridan Crawford, Inc. – A Tradition Continues

2000 Pacific Avenue
PO Box 128
Forest Grove, Oregon 97116
(503) 357-3154
Email info@wscinsurance.com
www.wscinsurance.com

**For more information about this Plan, please visit:
www.AHPCare.com/pacificu**

Important Notice

This information provides a brief description of the important features of the insurance plan. It is not a contract of insurance. The terms and conditions of coverage are set forth in the policy issued in the state in which the policy was delivered under form number AH-10331-OR. Complete details may be found in the policy on file at your school's office. The policy is subject to the laws of the state in which it was issued. Please keep this information as a reference.

IMPORTANT NOTICE

Insurance policies providing certain health insurance coverage issued or renewed on or after September 23, 2010 are required to comply with all applicable requirements of the Patient Protection and Affordable Care Act ("PPACA"). However, there are a number of insurance coverages that are specifically exempt from the requirements of PPACA (See §2791 of the Public Health Services Act). ACE maintains its student health insurance is not subject to PPACA.

ACE continues to monitor healthcare reform laws and regulations to determine any impact on its products. In the event these laws and regulations change, your plan and rates will be modified accordingly.

Please understand that this is not intended as legal advice. For legal advice on PPACA, please consult with your own legal counsel or tax advisor directly.

Privacy Disclosure

Under HIPAA's Privacy Rule, we are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You will receive a copy of ACE USA's HIPAA Privacy Notice upon request. Please write to Academic HealthPlans, Inc., P.O. Box 1605, Colleyville, TX 76034-1605 or call (817) 479-2100. You may also view and download a copy from the website at www.AHPCare.com/pacificu.