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<th>Page</th>
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<td>Summary of Benefits and Coverage (SBC)</td>
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<td>Welcome letter</td>
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<td>Student Health Plan eligibility information</td>
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<td>Terms you should know</td>
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<td>Network doctors and hospitals</td>
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</tr>
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<td>— What coverage costs and when it starts and ends</td>
<td>15</td>
</tr>
</tbody>
</table>

**Important information** — This is your plan’s current benefit summary. It gives you a brief description of the coverage under this plan and how to use its benefits. It is not the group contract. If anything in this benefit summary disagrees with the group contract, the contract prevails.

After enrolling in the Independence Administrators Student Health Plan, you will be able to find the complete benefit booklet via your online services. If you want to view the group contract, please see your Student Health Center or other appropriate school representative.

Independence Administrators Student Health Plan benefits are underwritten by QCC Insurance Company and administered by Independence Administrators, independent licensees of the Blue Cross and Blue Shield Association.
### Important Questions

<table>
<thead>
<tr>
<th>What is the overall deductible?</th>
<th>$0.</th>
<th>See the chart starting on page 2 for your costs for services this plan covers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. For Preferred providers $6,350 person / $12,700 family</td>
<td>The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premiums, balance-billed charges, health care this plan doesn't cover, and preauthorization penalties.</td>
<td>Even though you pay these expenses, they don't count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. See <a href="http://www.myibxtpastudent.com">www.myibxtpastudent.com</a> or call: 1-888-547-5080 for a list of Preferred providers.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No. You don't need a referral to see a specialist.</td>
<td>You can see the specialist you choose without permission from this plan.</td>
</tr>
<tr>
<td>Are there services this plan doesn't cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn't cover are listed on the Excluded Services &amp; Other Covered Services page. See your policy or plan document for additional information about excluded services.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-547-5080 or visit us at [www.myibxtpastudent.com](http://www.myibxtpastudent.com). If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf](http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf) or call 1-888-547-5080 to request a copy.
**Swarthmore College: Student Health Plan**  
**Coverage Period:** 08/17/2014 - 08/16/2015  
**Coverage for:** Individual  
**Plan Type:** PPO

**Summary of Benefits and Coverage: What this Plan Covers & What it Costs**

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven’t met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network provider charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **Preferred providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider's office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>---None---</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>---None---</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>20% coinsurance for chiropractor</td>
<td>20% coinsurance for chiropractor</td>
<td>Limited to 20 visits per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No Charge</td>
<td>20% coinsurance</td>
<td>Limitations may apply.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required for some diagnostic services.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required for some diagnostic services.</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-888-547-5080 or visit us at www.myibxtpastudent.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-547-5080 to request a copy.
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage Period:** 08/17/2014 - 08/16/2015

**Coverage for:** Individual | **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
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<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>20% coinsurance for retail and mail order</td>
<td>20% coinsurance for retail and mail order</td>
<td>Retail: 30-day supply. Mail order: 90-day supply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>20% coinsurance for retail and mail order</td>
<td>20% coinsurance for retail and mail order</td>
<td>Retail: 30-day supply. Mail order: 90-day supply.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>20% coinsurance for retail and mail order</td>
<td>20% coinsurance for retail and mail order</td>
<td>Retail: 30-day supply. Mail order: 90-day supply.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>20% coinsurance for retail and mail order</td>
<td>20% coinsurance for retail and mail order</td>
<td>Retail: 30-day supply. Mail order: 90-day supply.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required for some outpatient surgeries.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required for some outpatient surgeries.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Copay is waived if you are admitted. Non-emergency: $50 copay then 20% coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Must be medically necessary.</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$50 copay then 20% coinsurance</td>
<td>$50 copay then 20% coinsurance</td>
<td>Copay only applies when non-emergency.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td>Preauthorization is required.</td>
</tr>
</tbody>
</table>

---

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## Summary of Benefits and Coverage: What this Plan Covers & What it Costs

**Coverage Period:** 08/17/2014 - 08/16/2015  
**Coverage for:** Individual  |  **Plan Type:** PPO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>20% coinsurance</td>
<td>20% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

### If you have mental health, behavioral health, or substance abuse needs

- Mental/Behavioral health outpatient services
  - 20% coinsurance
  - 20% coinsurance
  - Limited to 30 visits per plan year.

- Mental/Behavioral health inpatient services
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required. Limited to 20 days per plan year.

- Substance use disorder outpatient services
  - 20% coinsurance
  - 20% coinsurance
  - ---None---

- Substance use disorder inpatient services
  - 20% coinsurance
  - 20% coinsurance
  - ---None---

### If you are pregnant

- Prenatal and postnatal care
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required.

- Delivery and all inpatient services
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required.

### If you need help recovering or have other special health needs

- Home health care
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required. Limited to 120 days per plan year.

- Rehabilitation services
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required. Limited to 20 visits per plan year.

- Habilitation services
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required. Limited to 20 visits per plan year.

- Skilled nursing care
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required. Limited to 120 inpatient days per plan year.

- Durable medical equipment
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required for Non-Participating supplies for items with a billed amount that exceeds $250 (includes replacements and repairs).

- Hospice service
  - 20% coinsurance
  - 20% coinsurance
  - Preauthorization is required.

---

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Swarthmore College: Student Health Plan

Coverage Period: 08/17/2014 - 08/16/2015

Coverage for: Individual | Plan Type: PPO

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use a Preferred Provider</th>
<th>Your Cost If You Use a Non-Preferred Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If your child needs dental or eye care</td>
<td>Eye exam</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Age 0 to 18 – 1 exam per calendar year.</td>
</tr>
<tr>
<td></td>
<td>Glasses</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Age 0 to 18 – 1 per calendar year. Contact lenses must be medically necessary with prior approval.</td>
</tr>
<tr>
<td></td>
<td>Dental check-up</td>
<td>No Charge</td>
<td>Not Covered</td>
<td>Age 0 to 18 – 1 exam every 6 months. Covers medically necessary Orthodontics. Dental benefits provided by United Concordia. For dental providers visit <a href="http://www.unitedconcordia.com">www.unitedconcordia.com</a>.</td>
</tr>
</tbody>
</table>

Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)**

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Hearing Aids
- Infertility Treatment
- Long Term Care
- Routine foot care
- Weight loss program

**Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Chiropractic care
- Dental care (Adult)
- Most coverage provided outside the U.S. (See www.ibxtpa.com)
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)

**Questions:** Call 1-888-547-5080 or visit us at www.myibxtpastudent.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-547-5080 to request a copy.
Your Rights to Continue Coverage:
Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-800-ASK-BLUE. You may also contact your state insurance department at The Pennsylvania Department of Insurance, 1326 Strawberry Square, Harrisburg, Pa. 17111 (877) 881-6388 or at www.insurance.pa.gov.

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: 1-888-547-5080 or www.myibxtpastudent.com. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact your state insurance department at The Pennsylvania Department of Insurance, 1326 Strawberry Square, Harrisburg, Pa. 17111 (877) 881-6388 or at www.insurance.pa.gov.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as “minimum essential coverage.” This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
English: For assistance in English, call 1-888-547-5080.
Spanish (Español): Para obtener asistencia en Español, llame al 1-888-547-5080.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-888-547-5080.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-888-547-5080.
Navajo (Dine): Dinek'ehgo shika a'ohwol ninisingo, kwiijiy holne' 1-888-547-5080.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.
### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

---

### Having a baby (normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $5,930
- **Patient pays:** $1,610

#### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

- **Deductibles:** $0
- **Copays:** $0
- **Coinsurance:** $1,460
- **Limits or exclusions:** $150
- **Total:** $1,610

---

### Managing type 2 diabetes (routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $4,270
- **Patient pays:** $1,130

#### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

- **Deductibles:** $0
- **Copays:** $0
- **Coinsurance:** $1,050
- **Limits or exclusions:** $80
- **Total:** $1,130

---

*This is not a cost estimator.*

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

---

Questions: Call 1-888-547-5080 or visit us at www.myibxtpastudent.com. If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-888-547-5080 to request a copy.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Independence Administrators is an independent licensee of the Blue Cross and Blue Shield Association.

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Choose the Independence Administrators Student Health Plan!

This benefit summary gives you information you need about the Independence Administrators Student Health Plan, its benefits, and resources that can help you take charge of your health and your health care.

IDENTIFICATION CARDS — IF YOU ENROLL
After you enroll in the Independence Administrators Student Health Plan you will receive an Independence Administrators ID card in the mail. You can begin using your new ID card on August 17, 2014. Your new card includes the Independence Administrators and FutureScripts® logos.

Be sure to present your new ID card to your health care providers and pharmacy. You do not have to take any action to activate your new card.

FREQUENTLY ASKED QUESTIONS
Q: What do I do if I am sick? Where do I go for medical care?
A: Visit your school’s Health Center first for treatment. If you need treatment for an emergency, then please seek care at an emergency room. If your school’s Health Center is closed, please seek care from a medical provider.

Q: Do I have to call Independence Administrators before I get medical care?
A: To make sure you receive the highest level of benefits for your eligible health care, you will need to have non-emergency hospital stays and certain surgeries and procedures precertified. Be sure to read the Schedule of Benefits and precertification requirements sections in this booklet.

Q: How can I find out if my doctor is in the network now?
A: Right now, you can visit www.myibxtpastudent.com to search the online network doctor and hospital directory.

CLICK OR CALL FOR INFORMATION AND RESOURCES
When you enroll in the Independence Administrators Student Health Plan, you will be able to access information and resources online at www.myibxtpastudent.com. Online services include:

• eligibility information
• benefits information
• claims information
• online directory of network doctors and hospitals
• decision-making support tools
• health-related sites and resources
• print temporary ID cards or request replacement ID cards

And when you get your ID card it will include your customer service phone number, which you can call to get answers to your questions.

We look forward to bringing you excellent service and resources to manage your health care needs!
**Eligibility**

Your school’s Plan provides benefits for students and dependents who meet the Plan’s eligibility requirements and enroll in the Plan. All students enrolled for a minimum of 12 credit hours are eligible to participate in the student health care program.

Open enrollment is available through August 17, 2014. Students can also enroll within 31 days of a “qualifying life event,” that causes you to lose coverage or changes your coverage status.

If your family or student status changes, tell your school immediately. You must request any changes to your coverage within 31 days of when you lose other coverage. If your school does not receive your request and documentation within 31 days, you must wait until the next open enrollment period to elect coverage.

**Terms You Should Know**

**Benefits** — What the Independence Administrators Student Health Plan covers for your health care.

**Coinsurance** — The percentages of the Plan’s allowance that you and the Plan pay for a covered health care service. For example, for a particular service, the Plan may pay 80% of what it allows, and you would be responsible for the other 20% of the allowance.

**Deductible** — A set dollar amount that you pay each year before the Independence Administrators Student Health Plan begins to pay benefits.

**Network doctors and hospitals** — Doctors and hospitals who have an agreement to accept the Plan’s allowance as full payment for services they perform. The Plan’s allowance includes the amount the Plan pays plus deductible, copayment, or coinsurance amounts that you are responsible for. If you use a non-network doctor or hospital, you may have to pay significantly more out of your pocket for the care you receive.

**Plan allowance** — The amount considered payable by the Independence Administrators Student Health Plan. You may be responsible to pay for part of the plan allowance, for example deductible or coinsurance.

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**Network Hospitals & Doctors**

**You can save money by using network providers!**

Whether you are at home or traveling throughout the U.S., you’ll enjoy access to doctors and hospitals through Independence Administrators’ network plus the BlueCard® Program of health care providers. BlueCard gives you access to health care providers who participate with independent Blue Cross® and Blue Shield® plans across the country.

Visit [www.myibxtpastudent.com](http://www.myibxtpastudent.com) or call the number on the back of your ID card to locate participating network providers.

Your Plan pays for covered medical charges billed by both network and out-of-network hospitals and doctors, so you choose your doctors and hospitals.

**You can save money when you use network doctors and hospitals** because they cannot bill you for amounts that exceed your Plan’s network fee schedule. Network providers may bill you only for deductible and coinsurance and amounts that exceed your Plan’s maximum benefits.

If you receive care from an out-of-network provider, your out-of-pocket expenses could increase — and that increase could be significant.

Your plan will cover the services at the appropriate out-of-network benefit. A higher level of cost-sharing may apply. For example, you may have to pay a higher deductible or coinsurance amount. Also, out-of-network health care providers may require that you pay in full at the time you receive care, and they may bill you for any balances over the amount your plan pays.

If you will be visiting other countries, be sure to read the BlueCard Worldwide® section within this booklet for information about global health and safety tools.
As an Independence Administrators Student Health Plan member, you will be able to access health benefits information through our secure online services.

When you enroll, you’ll have convenient access to benefits information, as well as resources and interactive tools to help you manage your health and wellness, 24/7.

Once you receive your ID card, you can visit www.myibxtpastudent.com to register for online access.

Personalized self-service

When you register, your personalized account will give you access to important health information for you and your dependents:

- print or view a temporary ID card
- order a replacement ID card
- view eligibility information
- view a summary of your benefit plan and precertification program
- find hospitals and doctors in the network
- view claims and Explanation of Benefit statements
- contact customer service
- download forms and other documents

Enjoy quick and convenient access to health plan information and resources

24/7 Nurse Helpline

Have a minor injury or illness?
— Need to visit your doctor?
— Maybe go to the ER?
— Not sure?

Call the 24/7 Nurse Helpline.
888-547-5080 ext. 4

As a member of the Independence Administrators Student Health Plan, you will have access to the 24/7 Nurse Helpline.

Experienced, multilingual registered nurses staff the line 24 hours a day, 365 days a year to answer your medical and health questions. Physician back-up is available in case it’s needed.

You’ll get immediate health information, and the RNs can direct you to the appropriate level of care for your illness or injury to help you reduce your health care costs.

You can call the helpline toll free — any time.

Single Toll-Free Number

One Call Does It All

Independence Administrators offers a single toll-free number to handle all questions and services. To make it even easier, this number is printed on your ID card for quick access when you need it.

With just one call you can review your account information with a customer service representative and get any of your questions answered. Or you can receive information about:

- Health Management programs
  - Patient Care Management/Precertification
  - Case Management
  - Baby Beginnings℠
  - CorCell®
- Mental and substance abuse services
- 24/7 Nurse Helpline

To speak to a customer service representative, please call 1-888-547-5080.
Prescription Drug Benefits

Your Independence Administrators Student Health Plan includes a prescription drug benefit plan that is administered by FutureScripts®.

Your prescription drug coverage requires prior authorization of certain covered drugs to ensure that the prescribed drug is medically necessary and appropriate and is being prescribed according to the Food and Drug Administration (FDA) guidelines.

When you receive your ID card, you can visit www.myibxtpastudent.com or call the number on your ID card to learn more about your prescription drug coverage and the prior authorization program.

Drugs that require prior authorization
You can view the list of prescription drugs that require prior authorization online by following these steps:

2. Select the Prescription Drug Benefits Program page.
3. Click the procedures that support safe prescribing link.

Or contact FutureScripts at 1-888-678-7013.

Without prior authorization, your prescription will not be covered at your health benefits program’s retail or mail order pharmacy. You may be able to get a 96-hour supply while FutureScripts processes the prior authorization request.

How to request a prior authorization/preapproval or override
The physician prescribing the medication completes a prior authorization form or writes a letter of medical necessity and faxes it to FutureScripts at 215-241-3073 or 1-888-671-5285. Or the physician may request the form by calling 1-888-678-7013. Plan members may request the form through Customer Service on their physician’s behalf, but the physician must complete and submit it.

FutureScripts will review the prior authorization request or letter of medical necessity. If a clinical pharmacist cannot approve the request based on established criteria, a medical director will review it.

FutureScripts®, a Catamaran™ company, is an independent company that provides pharmacy benefits management services to Independence Administrators.
Vision Discount Program

Your Independence Administrators Student Health Plan includes a vision care discount program that is administered by Davis Vision®.

With your discount vision program you can receive a comprehensive eye examination for $35 at participating Davis Vision providers.

The Davis Vision discount program also offers significant discounts on frames, lenses, and contact lenses.

Through Lens 123®, the Davis Vision proprietary mail order program, you may receive replacement contact lenses offered at guaranteed, discounted prices.

Laser Vision Correction Discounts
You can receive discounts on laser vision correction services at Davis Vision participating laser vision correction providers: up to 25 percent off the participating provider’s usual and customary fees or 5 percent off any participating provider’s advertised specials, whichever is less.

When you receive your ID card, you can visit www.DavisVision.com or call the number on your ID card to learn more about your vision care discount program and to locate participating providers.

Davis Vision, an independent company, provides discount vision program services for Independence Administrators plan members.

Pediatric Vision Benefits

The IA Student Health plan provides a Pediatric Vision Plan that complies with Affordable Care Act (ACA) requirements for students under age 19. If your plan covers dependents, the Pediatric Vision Plan also covers enrolled dependents age 0 to 18.

- Eye examination including dilation (when professionally indicated) – 1 per calendar year
- Spectacle lenses – 1 pair per calendar year
  - clear plastic single-vision, lined bifocal, trifocal, or lenticular lenses (any Rx)
  - oversized lenses
  - tinting of plastic lenses
  - scratch-resistant coating
  - polycarbonate lenses
- Frame – 1 per calendar year
- Medically necessary contact lenses (with prior approval)
  - materials, evaluation, fitting, and follow-up care

Pediatric Dental Program

The IA Student Health plan provides a Pediatric Dental Plan that complies with Affordable Care Act (ACA) requirements for students under age 19. If your plan covers dependents, the Pediatric Dental Plan also covers enrolled dependents age 0 to 18.

The plan provides exams, x-rays, and cleanings along with other basic covered, ACA-approved benefits. There is no cost to the member when you use a dental provider who participates in the United Concordia network.

The Pediatric Dental Benefits are administered by United Concordia. For more information, please contact United Concordia at 1-866-568-5994 or visit www.ucci.com.

The dental products are offered independently by United Concordia. This is not an Independence Administrators product. United Concordia is solely responsible for the dental products.
Precertification Program

You, your doctor, or your hospital must call the customer service number on your ID card to fulfill your Plan’s precertification requirements.

You must certify all inpatient hospital admissions and certain surgical and diagnostic procedures (listed here).

- **For non-emergency admissions or procedures** — Call for precertification before you enter the hospital or undergo the procedure.
- **For emergency admissions** — Call for precertification within 48 hours or 2 business days after the admission.
- **For emergency surgery or diagnostic procedures relating to emergency services** — Call for precertification within one working day, or as soon as reasonably possible.
- **For transplant services** — Call as soon as your doctor confirms the need for an organ or tissue transplant.
- **For maternity prenotification** — Call as soon as you confirm the pregnancy.

What procedures require precertification?

**Inpatient care**
- Hospital inpatient admissions
- All inpatient surgery and procedures
- Psychiatric and substance abuse inpatient and partial admissions
- Rehabilitation admissions
- Skilled nursing facility admissions, subacute and long term acute care admissions

**Diagnostic procedures**
- PET, CT, CTA, MRA, MRI scans
- Cardiac blood pool imaging or MUGA
- Myocardial perfusion imaging
- Single Photo Emission Computerized Tomography (SPECT)

Ancillary Services
- Hospice
- Home health care
- Home infusion
- Private duty nursing
- Non-emergency ambulance

Outpatient surgical procedures
- Arthroplasty
- Arthroscopy, diagnostic and surgical (includes arthroscopic knee surgery)
- Bariatric procedures and surgery including gastric bypass
- Bunionectomy
- Carpal tunnel release
- Hernia repair (ventral and abdominal; not inguinal)
- Hip, total
- Hysterectomy
- Knee, total
- Pain management services that include injections and blocks: epidural, facet, and trigger point
- Penile prosthesis insertion
- Sinus surgery
- Spinal/vertebral surgery
- Temporomandibular joint surgery
- Treatment of medical complications of cosmetic surgery
- Uvulopalatopharyngoplasty (UPP)
- Wisdom teeth removal/oral surgery performed in Short Procedure Unit (SPU)

Potential cosmetic/reconstructive procedures
- Surgery and procedures that are potentially cosmetic in nature, such as, but not limited to: abdominoplasty; breast implants, insertion; dermabrasion; and scar revision.

Therapy, restorative, and durable medical equipment services
- Cardiac/pulmonary rehabilitation
- Prosthesis/orthotics
- Durable medical equipment over $250
- Outpatient cancer chemotherapy

For medical or surgical precertification, call Patient Care Management at the number on your ID card. For mental health and substance abuse precertification, call Patient Care Management or Magellan Behavioral Health at the number on your ID card. Precertification services are available 24 hours a day, 7 days a week, including holidays.

Medical management services are provided by AmeriHealth Administrators, an independent company. Magellan Behavioral Health is an independent company providing behavioral health services.
**Health Resources**

**Case Management**
Case management serves plan members (you and your enrolled family members) who are diagnosed with a complex, catastrophic, or chronic illness or injury.

It supports you and your health care providers by locating, coordinating, and evaluating services across various levels and places of care.

**Case management objectives**
- Facilitate your access to doctors, hospitals, and health care professionals to ensure the efficient use of appropriate health care resources
- Connect you with appropriate health care or support services
- Help coordinate prescribed services
- Monitor the quality of services
- Improve your health outcomes

**Participating in case management**
Case management is voluntary. You decide if you want to take advantage of case management.

There is no penalty if you choose not to participate — your benefits will remain the same.

**How it works**
A case manager will consult with you, your authorized representative, caregiver, and your treating doctors to develop a case management plan of care for you. The case manager will review this plan with you and your doctors throughout your enrollment in the program.

This plan of care may include some or all of the following:
- Personal support
- Contacting the caregiver to offer assistance and support
- Monitoring in-patient care
- Identifying resources for appropriate care; determining alternative care options; and assisting in obtaining any medically necessary equipment and services

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

The case management program is confidential and is provided at no cost to you. You can get more information by contacting Patient Care Management at 1-888-234-2393.

**NICU Care Management**
Independence Administrators offers support to plan members if their newborn needs treatment in a Neonatal Intensive Care Unit (NICU).

This program provides telephone and in-person support to families when their babies are in special care nurseries in the hospital. This support continues from the day the baby is admitted through discharge planning and the transition home.

**NICU care management objectives**
- Coordinate care for high-risk and premature newborns from admission through discharge planning
- Consult with physicians and nurses to ensure best care is received

Participation in NICU care management is voluntary and confidential. This benefit is provided at no cost to you. A care manager will reach out to the family when an infant is admitted to the NICU.

Care managers help families:
- understand medical terms
- communicate with doctors and nurses
- learn about the NICU environment
- understand the goals a baby needs to reach before coming home
- prepare for the baby to come home and caring for the baby after leaving the hospital

AmeriHealth Administrators, an independent company, provides medical management services and programs for Independence Administrators. The Neonatal Intensive Care Unit (NICU) care management program is administered by Alere™ Women’s and Children’s Health, a division of the Alere group of companies, a separate group of companies.
Health Resources

WebMD®
We’ve joined with WebMD®, one of the most widely-known names in health information, to deliver up-to-date, reliable data and tools to help you make decisions that are right for you.

Get help getting healthy
Lifestyle changes such as quitting smoking may seem overwhelming, but at www.myibxtpastudent.com you can get started, set goals, and track your progress — all for free.

Personal Health Record – Securely store, manage, and maintain your personal health information online.

Personal Health Profile – Get a clear picture of what you are doing right and learn ways to stay healthy. Just answer a few questions to get your confidential, personalized plan.

My Health Assistant – A health improvement support tool that allows for creation of personalized health plans, goal setting and progress tracking, access to a library of relevant content, and community interaction with individuals working on similar behavior changes.

Health Management Center – This support tool provides helpful information, resources, quizzes, and tools based on Personal Health Profile results, including online behavior change programs.

Get reliable health information
Symptom Checker helps you understand your symptoms and what to do about them.

Health Topics offers information on more than 160 health topics and the latest news on common conditions.

Health Plan Selector estimates costs of different health plan options; now expanded to include an HSA advisor.

Hospital Quality Reports help you identify hospitals that are best equipped to handle your needs.

After you’ve enrolled, you can access WebMD at www.myibxtpastudent.com.

WebMD is an independent company offering online health information and wellness education to Independence Administrators.

Blue365®
Living well requires making healthy choices every day. Independence Administrators wants to help you make those choices and is pleased to provide you with access to exclusive value-added discounts and offers from leading national companies through Blue365®.

With Blue365, you can stay healthy and save money by taking advantage of discounts* on the following products and services:

- fitness memberships and equipment
- weight loss plans
- laser vision correction
- senior care services
- hearing aids
- alternative health services
- healthy travel

*Blue365 discount offers are subject to change at any time. Most discounts are free; some require a fee to access discounts.

In addition, you’ll find informative articles on topics such as weight management, nutrition, child and senior health, emotional wellness, and more.

After you’ve enrolled, you can access Blue365 at www.myibxtpastudent.com.

Blue365 offers access to savings on items that plan members may purchase directly from independent vendors. Blue365 does not include items covered under your group health plan administered by Independence Administrators. The Blue Cross and Blue Shield Association (BCBSA)* may receive payments from Blue365 vendors. Neither BCBSA nor Independence Administrators recommends, endorses, warrants, or guarantees any specific Blue365 vendor or item. Discount offers are subject to change at any time.

The Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield Plans.

Blue365® Your resource for living healthier,*
Baby Beginnings® offers support to help pregnant women throughout their pregnancy and up to six weeks after the birth of the baby.

The Baby Beginnings maternity program helps make your pregnancy experience a healthy and happy one by offering:

- confidential pregnancy assessments
- a comprehensive book about pregnancy, delivery, and baby care
- educational information tailored to your needs
- a 24/7 support line where nurses specializing in maternity care and NICU are available to answer questions

Baby Beginnings also provides support for special care cases in the event you develop complications with your pregnancy or if your new baby requires neonatal intensive care. Your maternity nurse will work with you to help you understand what is happening, answer your questions, and continue to help with any special needs.

Enrolling with Baby Beginnings does not take the place of providing prenotification of your maternity services. Please provide prenotification as soon as you confirm your pregnancy.

Baby Beginnings is free and confidential. To learn more about the Baby Beginnings program visit www.myibxtpastudent.com.

CorCell®

Saving your child’s umbilical cord blood stem cells could protect your child or another family member from a growing number of life-threatening diseases. You can take advantage of this opportunity through the CorCell® — Saving Baby’s Blood program.

You and your family members are eligible for a discount with CorCell, an industry leader in cord blood collection.

Cord blood stem cells can be collected only within minutes of the birth of a child. While it is never too late to enroll with CorCell, arrangements should be made at least six weeks in advance of a baby’s birth.

Your enrollment fee will secure your place with CorCell. Flexible payment options, along with the discount available through Independence Administrators, can make cord blood stem cell storage with CorCell truly affordable.

To receive more information on saving your baby’s cord blood stem cells with CorCell call toll free at 1-888-326-7235 or visit www.corcell.com.

CorCell is an independent company that offers services for the collection and storage of umbilical cord blood for potential use in future treatment of a variety of conditions.
Wherever and whenever you travel internationally, BlueCard Worldwide® makes it easy for you to locate a provider—24 hours a day, 7 days a week. Online or over the phone, you'll find the information you need.

BlueCard Worldwide offers:

- hospitals and doctors in more than 200 countries and territories around the world;
- 800 and collect-call number for 24-hour member assistance;
- searchable, online provider directory;
- detailed provider information;
- medical assistance services with help arranging a physician appointment or hospitalization, if necessary.

Information for travel destinations

The BlueCard Worldwide website offers members extensive online travel information, resources and references for specific destinations.

Here are a few of the tools and resources that will be available to you:

- create customized destination reports and maps;
- get detailed health reports, including suggested immunizations, recent outbreaks, health advisories, and food-and-water precautions;
- find helpful emergency numbers, telephone codes and a currency converter;
- download International claim forms and BlueCard Worldwide Brochures.

Plan before you travel

Start your trip on the right foot.

Visit www.myibxtpastudent.com to access the BlueCard WorldWide website. To log on, you will need your Independence Administrators ID number—starting with the three-letter alpha prefix—located on your ID card.

To learn more about the BlueCard Worldwide program:
Visit www.myibxtpastudent.com
Call 1-800-810-2583 (toll-free) or 1-804-673-1177 (collect)
Important information about your appeal rights

You have a right to appeal any decision not to pay for an item or service (in whole or in part). You also have a right to appeal if your health care enrollment is rescinded. If you do not agree with the outcome of the appeal, you may be able to request an external review.

You may ask for copies of all the relevant information we used to make a decision, at no charge. Call us at the number on your ID card.

Independence Administrators has authorized AmeriHealth Administrators to perform certain appeals activities and services.

How do I file an appeal if I disagree with a decision?
Within 180 days after you receive notice of the decision, contact us as instructed in the notice. You may supply any additional information that supports your request.

Who may file an appeal?
You or someone you name to act for you (your authorized representative) may file an appeal. If you want to name an authorized representative, call us at the service number on your ID card.

What if my situation is urgent?
If your situation meets the definition of urgent under the law, we will expedite your review.

Generally, a situation is urgent if your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal.

Coordination of Benefits

When you or your covered dependents are covered under more than one group health plan, the primary plan will determine benefits first, regardless of benefits provided under any other group health plan.

When this Plan is the secondary payer, it will coordinate payment with the primary plan so that the total of both plans payments does not exceed the amount this Plan would have paid if it were primary.

If you believe your situation is urgent, you may call us at the number on your ID card to request an expedited appeal.

What happens next?
We will review the information, make a decision, and send you an updated Explanation of Benefits statement or a letter to notify you of the decision.

If we continue to deny payment or coverage, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

What if I need help understanding a denial letter?
Call us at the number listed on the letter if you need help understanding the notice or our decision to deny payment or coverage.

Other resources to help you
For questions about your appeal rights, you may contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.askebsa.gov. A consumer assistance program in your state may also be able to help you.

Appealing a pharmacy claim decision
Your right to an appeal also applies if you request prior authorization of a prescription drug and it is denied. You or your authorized representative may file an appeal. To file an appeal, call the phone number or write to the address in the denial notice.

When You Have a Claim

From a network doctor or facility
Show the health care provider your Independence Administrators ID card. The network doctor or hospital will submit a claim for you, and Independence Administrators will pay the provider directly for covered expenses.

From a non-network doctor or facility
If the facility or doctor has you pay for the service right away, be sure to get an itemized bill with a receipt.

Besides the itemized charges, the receipt should show:
• student’s name and address
• member ID number
• patient’s name and age
• doctor’s or hospital’s name and address
• date you were admitted or treated

Send the receipt to the address on your ID card.
Exceptions and Exclusions

This is a partial list of some exclusions included in the group contract. It is not a complete list of exclusions. When you enroll, you can find the full list of exclusions in the benefit booklet available through Independence Administrators.

Except as specifically provided in the Plan, no benefits will be provided for the following services, supplies, or charges:

1. for any service, treatment, surgery, supply, drug, or medicine that:
   a.) is not medically necessary for the care or treatment of an accidental injury or illness; or
   b.) is not recommended by a doctor; or
   c.) is experimental or investigational, except as approved by Independence Administrators, routine costs associated with a qualifying clinical trial that meets the definition of a qualifying clinical trial under the contract;

2. in excess of the plan's allowance;

3. incurred before the effective date coverage begins under the contract;

4. incurred on or after the date coverage ends under the contract, except as provided in your group contract;

5. for premarital or pre-employment examinations, rest cures, research studies, or any other services or supplies that are not necessary for the diagnosis, care, or treatment of an illness or accidental injury, unless specifically included in the contract;

6. for personal hygiene, convenience items, and non-medical items such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, television, beauty/barber shop services, or guest tray, whether or not recommended by a doctor;

7. for eye examinations, eyeglasses, sunglasses (including cataract sunglasses), safety glasses, and examinations for the fitting and prescription thereof unless specifically provided in the contract;

8. for the treatment of infertility, including drugs or medication (other than those services necessary to diagnose the cause of infertility) and surgical correction;

9. for any service, treatment, surgery, supply, drug, or medicine furnished by a spouse, parent, or child of a covered person for whom the charge is being made;

10. for any service, treatment, surgery, supply, or drug and medicine furnished for the care of any accidental injury or illness that is covered by workers’ compensation or occupational disease law;

11. for services for which there is no legal obligation to pay;

12. for any service, treatment, surgery, supply, drug, or medicine that a covered person is eligible to receive from: the Veterans Administration Hospital for which the covered person has no legal obligation to pay; or the Department of Defense for active military personnel for which a covered person is eligible.

This exclusion applies even if the covered person has not taken the necessary action to obtain such benefits.

13. for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle coverage, including a certified self-insurance plan, or payable in any manner under the Pennsylvania Motor Vehicle Financial Responsibility law;

14. for treatment of temporomandibular joint syndrome with intra-oral devices, or other method to alter vertical dimension;

15. for weight management; services and supplies related to weight reduction programs; related nutritional supplies; and treatment of obesity, including gastric bypass surgery and other obesity-related surgeries and procedures;

16. for expenses incurred for services normally provided without charge by the Educational Institution's health service, infirmary or hospital, or by health care providers employed by the Educational Institution;

17. for expense incurred for Accidental Injury resulting from the travel to, or play or practice of interscholastic, intercollegiate, or professional sports activity.
Definitions

Accidental injury
A sudden, unforeseen and identifiable event causing injury to a covered person that is the direct result of the injury and occurs while coverage for the covered person is in force under the contract.

Hospital
A short-term, acute care general hospital that is a duly licensed institution; and
a) is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, care, and treatment of sick and injured persons, by or under the supervision of doctors; and
b) has organized departments of medicine; and
c) provides continuous 24-hour nursing service by or under the supervision of registered nurses; and
d) is approved by the Joint Commission on Accreditation of Healthcare Organization, and/or by the American Osteopathic Hospital Association, or by Independence Administrators.

A hospital is not, other than incidentally, a:
• nursing home
• place for rest
• place for the aged
• skilled nursing facility
• place for the provision of hospice care
• place for the provision of rehabilitation care
• place for the treatment of alcoholism or drug abuse
• place for the treatment of mental illness
• spa or sanitarium

Illness
A condition marked by pronounced deviation from the normal, healthy state.

Medically appropriate/medically necessary
An intervention will be covered if it is:
a) a covered service;
b) not specifically excluded; and
c) medically appropriate/medically necessary.

An intervention is medically appropriate/medically necessary if, as ordered by the treating professional provider and determined by Independence Administrators' medical director or physician designee, it meets all of the following criteria:

a) It is a health intervention. A health intervention is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat, or palliate) a medical condition or to maintain or restore functional ability. A medical condition is one of the following: disease; illness; injury; genetic or congenital defect; pregnancy; biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

A health intervention is defined not only by the intervention itself but also by the medical condition and patient indications for which it is being applied.
b) It is the most appropriate supply or level of service, considering the potential benefit and harm to the covered person.
c) It is known to be effective in improving health outcomes. Effective means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outweigh potential harmful effects. Health outcomes are outcomes that affect health status. The effectiveness of an intervention is based upon being a "new" or "existing" intervention.

New interventions
Effectiveness is determined by scientific evidence. An intervention is considered new if it is not yet in widespread use for the medical condition or the patient indications being considered.

Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used.

Partially controlled observational studies and uncontrolled clinical series may be suggestive. These do not by themselves demonstrate a causal relationship unless the magnitude of the effect exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.

New interventions for which clinical trials have not been conducted because of epidemiological reasons (such as rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion.
Existing Interventions
Effectiveness is determined first by scientific evidence, then by professional standard, then by expert opinion. For existing interventions, scientific evidence should be considered first and, to the greatest extent possible, be the basis for determining medical necessity.

If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion.

Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the contractual definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

The next step is determining cost effectiveness of the existing intervention for this condition compared to alternative interventions, including no intervention. “Cost effective” does not necessarily mean lowest price. An intervention is considered cost effective if the benefit and harm relative to costs represent an economically efficient use of resources for patients with this condition. The characteristics of the individual patient determine the application of this criterion to an individual case.

An intervention may be medically indicated yet not be a covered service or meet this medically appropriate/medically necessary definition.

Precertification
Prior assessment by Independence Administrators’ designated agent that proposed services, such as hospitalization, are medically necessary for a covered person.

Payment of the services depends on whether the services and the covered person are covered under the contract.
Contributions — 2014-2015 school year

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Spring Semester</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Only</td>
<td>$1,183</td>
<td>$806</td>
</tr>
<tr>
<td>Student &amp; Spouse</td>
<td>$3,857</td>
<td>$2,584</td>
</tr>
<tr>
<td>Each Child (additional)</td>
<td>$1,889</td>
<td>$1,268</td>
</tr>
</tbody>
</table>

Rates include all administrative fees.

Contract Terms

Effective date
Coverage under this plan takes effect on August 17, 2014.

The effective date for the contract coverage for students, spouses, and their children will become effective on the later of the following:

1) the effective date of this plan; or

2) the effective date of the applicable contract term for which the contribution is paid.

Termination date
Coverage under the contract will terminate on the earliest date on which one of the following occurs:

- the date the contract ceases to be in force;
- the end of the period for which the contribution has been paid;
- the date you begin full-time service in any Armed Forces. Send us proof of service and we will refund the contribution paid for at this time. This does not include Reserve or National Guard duty or training.

For dependents

- the date the covered student ceases to be covered under the contract or the date the dependent ceases to be an eligible dependent.