



2019-20 Student Injury and Sickness Insurance

DUE TO THE EARLY POSTING THIS IS ONLY A BRIEF BENEFIT SUMMARY WITH NO CHANGES ANTICIPATED. PLEASE REFER TO THE STUDENT PLAN BROCHURE OR MASTER POLICY WHEN AVAILABLE FOR A COMPLETE LISTING OF COVERED SERVICES, LIMITATIONS, DEFINITIONS AND EXCLUSIONS.

**if you have any questions or concerns, please call EIIA
at 888-255-4029 for assistance.**



Schedule of Benefits

IHECT-MN-Gold Enhanced 1

2018-203096-68

METALLIC LEVEL – GOLD WITH ACTUARIAL VALUE OF 84.120%

Injury and Sickness Benefits

No Overall Maximum Dollar Limit (Per Insured Person, Per Policy Year)

Deductible Preferred Provider	\$250 (Per Insured Person, Per Policy Year)
Deductible Out-of-Network	\$600 (Per Insured Person, Per Policy Year)
Coinsurance Preferred Provider	80% except as noted below
Coinsurance Out-of-Network	60% except as noted below
Out-of-Pocket Maximum Preferred Provider	\$6,850 (Per Insured Person, Per Policy Year)
Out-of-Pocket Maximum Preferred Provider	\$13,700 (For all Insureds in a Family, Per Policy Year)
Out-of-Pocket Maximum Out-of-Network	\$15,000 (Per Insured Person, Per Policy Year)

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness.

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. If the Covered Medical Expense is incurred for Emergency Services when due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. Covered Medical Expenses incurred at a Preferred Provider facility by an Out-of-Network Provider will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% for the remainder of the Policy Year subject to any benefit maximums or limits that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Any applicable Coinsurance, Copays, or Deductibles will be applied to the Out-of-Pocket Maximum. Services that are not Covered Medical Expenses and the amount benefits are reduced for failing to comply with Policy provisions or requirements do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Out-of-Network Copays.

Student Health Center Benefits: The Deductible and Copays will be waived and benefits will be paid at 100% for Covered Medical Expenses incurred when treatment is rendered at the Student Health Center.

Benefits are calculated on a Policy Year basis unless otherwise specifically stated. When benefit limits apply, benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Please refer to the Medical Expense Benefits – Injury and Sickness section of the Certificate of Coverage for a description of the Covered Medical Expenses for which benefits are available. Covered Medical Expenses include:

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expense	Preferred Allowance	Usual and Customary Charges
Intensive Care	Preferred Allowance	Usual and Customary Charges
Hospital Miscellaneous Expenses	Preferred Allowance	Usual and Customary Charges
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness

Inpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Registered Nurse's Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	Preferred Allowance	Usual and Customary Charges
Pre-admission Testing Payable within 7 working days prior to admission.	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery If two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	Preferred Allowance	Usual and Customary Charges
Day Surgery Miscellaneous	Preferred Allowance	Usual and Customary Charges
Assistant Surgeon Fees	Preferred Allowance	Usual and Customary Charges
Anesthetist Services	Preferred Allowance	Usual and Customary Charges
Physician's Visits	\$25 Copay per visit 100% of Preferred Allowance	Usual and Customary Charges
Physiotherapy Review of Medical Necessity will be performed after 12 visits per Injury or Sickness.	Preferred Allowance	Usual and Customary Charges
Medical Emergency Expenses The Copay will be waived if admitted to the Hospital.	\$150 Copay per visit 100% of Preferred Allowance	\$150 Copay per visit Usual and Customary Charges
Diagnostic X-ray Services	Preferred Allowance	Usual and Customary Charges
Radiation Therapy	Preferred Allowance	Usual and Customary Charges
Laboratory Procedures	Preferred Allowance	Usual and Customary Charges
Tests & Procedures	Preferred Allowance	Usual and Customary Charges
Injections	Preferred Allowance	Usual and Customary Charges
Chemotherapy	Preferred Allowance	Usual and Customary Charges

Outpatient	Preferred Provider	Out-of-Network Provider
Prescription Drugs *See UHCP Prescription Drug Benefit for additional information.	*UnitedHealthcare Pharmacy (UHCP), \$25 Copay per prescription Tier 1 \$45 Copay per prescription Tier 2 \$60 Copay per prescription Tier 3 up to a 31-day supply per prescription When Specialty Prescription Drugs are dispensed at a Non-Preferred Specialty Network Pharmacy, the Insured is required to pay 2 times the retail Copay (up to 50% of the Prescription Drug Charge). Mail order Prescription Drugs through UHCP at 2.5 times the retail Copay up to a 90-day supply.	No Benefits

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	100% of Preferred Allowance	80% of Usual and Customary Charges
Durable Medical Equipment	Preferred Allowance	80% of Usual and Customary Charges
Consultant Physician Fees	\$25 Copay per visit 100% of Preferred Allowance	Usual and Customary Charges
Dental Treatment	Preferred Allowance	80% of Usual and Customary Charges
Mental Illness Treatment	Paid as any other Sickness	Paid as any other Sickness
Substance Use Disorder Treatment See Benefits for Alcoholism, Chemical Dependency and Drug Addiction	Paid as any other Sickness	Paid as any other Sickness
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services No Deductible, Copays, or Coinsurance will be applied when the services are received from a Preferred Provider. Please visit https://www.healthcare.gov/preventive-care-benefits/ for a complete list of services provided for specific age and risk groups.	100% of Preferred Allowance	No Benefits
Reconstructive Breast Surgery Following Mastectomy See Benefits for Reconstructive Surgery	Paid as any other Sickness	Paid as any other Sickness
Diabetes Services	Paid as any other Sickness	Paid as any other Sickness
Home Health Care	Preferred Allowance	Usual and Customary Charges
Hospice Care	Preferred Allowance	Usual and Customary Charges
Inpatient Rehabilitation Facility	Preferred Allowance	Usual and Customary Charges
Skilled Nursing Facility	Preferred Allowance	Usual and Customary Charges
Urgent Care Center	\$50 Copay per visit 100% of Preferred Allowance	\$50 Copay per visit Usual and Customary Charges

Other	Preferred Provider	Out-of-Network Provider
Hospital Outpatient Facility or Clinic	Preferred Allowance	Usual and Customary Charges
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	Paid as any other Sickness	Paid as any other Sickness
Pediatric Dental and Vision Services	See Pediatric Dental and Vision Services benefits	See Pediatric Dental and Vision Services benefits
Genetic Testing	Paid as any other Sickness	Paid as any other Sickness
Medical Foods See also Benefits for Phenylketonuria Treatment	Preferred Allowance	Usual and Customary Charges
Ventilator Benefits See Benefits for Ventilator Dependency	Paid as any other Sickness	Paid as any other Sickness
Port-Wine Stain Elimination See Benefits for Port-Wine Stains	Paid as any other Sickness	Paid as any other Sickness
Lyme Disease See Benefits for Lyme Disease Treatment	Paid as any other Sickness	Paid as any other Sickness
Hearing Aids See Hearing Aids for Individuals 18 Years of Age or Younger	Paid as any other Sickness	Paid as any other Sickness
Titers (Coverage only includes titers related to immunizations for the following: Polio Virus Immune status, Varicella-Zoster AB, IgG, Hepatitis B surf AB, MMR, Hep B, Hep A, Tdap, and Rubella.)	Preferred Allowance	Usual and Customary Charges
Tuberculosis Screening and Testing (Coverage includes TB Screening and testing not covered under the Preventative Care Services Benefit.)	Preferred Allowance	Usual and Customary Charges

Section 10: Exclusions and Limitations

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

1. Acupuncture.
2. Addiction, such as:
 - Caffeine addiction.
 - Non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious.
 - Codependency.
3. Behavioral problems. Conceptual disability. Developmental delay or disorder or intellectual disability. Learning disabilities. Milieu therapy. Parent-child problems.
This exclusion does not apply to benefits specifically provided in the Policy.
4. Circumcision.
5. Cosmetic procedures, except reconstructive procedures to:
 - Correct an Injury or treat a Sickness for which benefits are otherwise payable under the Policy. The primary result of the procedure is not a changed or improved physical appearance.
 - Remove port wine stains.
 - As described under Benefits for Reconstructive Surgery.
6. Custodial Care.
 - Care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care.
 - Extended care in treatment or substance abuse facilities for domiciliary or Custodial Care.
7. Dental treatment, except:
 - For accidental Injury to Sound, Natural Teeth.
 - As specifically provided in the Schedule of Benefits.
 - As described under Dental Treatment in the Policy.

This exclusion does not apply to benefits specifically provided in Pediatric Dental Services.
8. Elective Surgery or Elective Treatment.
9. Elective abortion.
10. Flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline.
11. Foot care for the following:
 - Flatfoot conditions.
 - Supportive devices for the foot.
 - Fallen arches.
 - Weak feet.
 - Chronic foot strain.
 - Routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery).

This exclusion does not apply to preventive foot care for Insured Persons with diabetes.
12. Genetic testing, except as specifically provided in the Policy.
13. Health spa or similar facilities. Strengthening programs.
14. Hearing examinations. Hearing aids. Other treatment for hearing defects and hearing loss. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
This exclusion does not apply to:
 - Hearing defects or hearing loss as a result of an infection or Injury.
 - External hearing aids or bone anchored hearing aids once every 3 years for an Insured Person age 18 or younger with a hearing loss that is not correctable by other services provided in the Policy.
15. Hirsutism.
16. Hypnosis.
17. Immunizations, except as specifically provided in the Policy. Preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the Policy.
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law

or Act, or similar legislation.

19. Injury sustained from playing, practicing, traveling to or from, or participating in, or conditioning for any intercollegiate sport for which benefits are paid under a sports accident policy issued to the Policyholder, or for which coverage is provided by the National Collegiate Athletic Association (NCAA), National Association of Intercollegiate Athletics (NAIA) or any other sports association.
20. Investigational services.
21. Lipectomy.
22. Commission of or attempt to commit a felony.
23. Prescription Drugs, services or supplies as follows:
 - Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Policy.
 - Immunization agents, except as specifically provided in the Policy
 - Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs, except as specifically provided in Benefits for Cancer Drug Coverage.
 - Products used for cosmetic purposes.
 - Drugs used to treat or cure baldness. Anabolic steroids used for body building.
 - Anorectics - drugs used for the purpose of weight control.
 - Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra.
 - Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
24. Reproductive/Infertility services including but not limited to the following:
 - Procreative counseling.
 - Genetic counseling and genetic testing, except as specifically provided in the Policy under the Genetic Testing benefit.
 - Cryopreservation of reproductive materials. Storage of reproductive materials.
 - Infertility treatment (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception, except to diagnose the underlying cause of the infertility.
 - Premarital examinations.
 - Impotence, organic or otherwise.
 - Female sterilization procedures, except as specifically provided in the Policy.
 - Vasectomy.
 - Reversal of sterilization procedures.
25. Research or examinations relating to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the Policy.
26. Routine eye examinations. Eye refractions. Eyeglasses. Contact lenses. Prescriptions or fitting of eyeglasses or contact lenses. Vision correction surgery. Treatment for visual defects and problems.

This exclusion does not apply as follows:

 - When due to a covered Injury or disease process.
 - To benefits specifically provided in Pediatric Vision Services.
 - To the initial evaluation, fitting, and initial pair of eyeglasses or contact lenses for: a) the post-operative treatment of cataracts; and b) the treatment of aphakia or keratoconus.
27. Routine Newborn Infant Care and well-baby nursery and related Physician charge, except as specifically provided in the Policy.
28. Preventive care services which are not specifically provided for Preventive Care Services or any screening or testing in the Mandated Benefits section in the Policy, including:
 - Routine physical examinations and routine testing.
 - Preventive testing or treatment.
 - Screening exams or testing in the absence of Injury or Sickness.
29. Services provided normally without charge by the Health Service of the Policyholder. Services covered or provided by the student health fee.
30. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia. Deviated nasal septum, including submucous resection and/or other surgical correction thereof. Nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic sinusitis.
31. Sleep disorders.
32. Speech therapy, except as specifically provided in the Policy.
33. Stand-alone multi-disciplinary smoking cessation programs. These are programs that usually include health care providers specializing in smoking cessation and may include a psychologist, social worker or other licensed or certified professional. This exclusion does not apply to benefits specifically provided in Preventive Care Services.
34. Supplies, except as specifically provided in the Policy.

35. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia, except as specifically provided in the Policy.
36. Treatment where there is no legal obligation for the Insured Person to pay for such treatment.
37. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered).
38. Weight management. Weight reduction. Nutrition programs. Treatment for obesity. Surgery for removal of excess skin or fat. This exclusion does not apply to benefits specifically provided in Preventive Care Services or as specifically provided in the Policy.