

STUDENT  
HEALTH  
INSURANCE  
PLANS  
2004–2005  
FOR STUDENTS OF



Argosy University  
Western State University

Insured Through:  
TIG PREMIER INSURANCE COMPANY  
Tinton Falls, NJ  
Policy #18011  
Group # TP SI0001

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*USI and TIG Premier Insurance Company are wholly separate from Argosy University and Western State University, and Argosy University and Western State University have no financial interest in their operations, nor does Argosy University and Western State University make any representation as to the quality or adequacy of medical care or insurance coverage provided to any student during his or her enrollment at Argosy University or Western State University.*

## ELIGIBILITY

ALL STUDENTS of Argosy University/Western State University who are enrolled at least half-time in a degree seeking program are eligible for this medical plan. In order to be accepted, students must enroll within 31 days of the effective date for term applied.

DEPENDENT COVERAGE is available. Insured Students may also enroll their eligible dependents in the plan.

An eligible Dependent is:

- 1) an Insured Student's spouse, who is not legally separated from the Insured Student; or
- 2) the unmarried child or children under age 19, or up to age 25 if a full-time student, who are not self-supporting. Dependent coverage will not be effective prior to that of the Insured Student or extend beyond that of the Insured Student.

A child of an Insured Student or an Insured spouse will be covered under the Policy for the first 31 days after:

- 1) birth of a Newborn Child;
- 2) the effective date of adoption of the child; or
- 3) the date of placement of the child for adoption.

The Insured Student will have the right to continue such coverage for the child beyond 31 days. To continue the coverage the Insured must, within 31 days after the birth, adoption or placement for adoption:

- 1) apply for coverage; and
- 2) pay the required additional premium. If the Insured Student does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth, adoption or placement for adoption.

**"Newborn Child"** means:

- 1) a newly born child of the Insured Student from the moment of birth provided that the Insured Student is insured under the Policy;
- 2) a child to whom a decree of adoption by the Insured Student has been entered within thirty-one days after the date of the child's birth and the Insured Student has temporary custody of the child provided the person adopting the child is Insured under the Policy on the date the child is placed with the Insured Student; and
- 3) a child adopted by the Insured Student whose adoption proceedings have been completed and a decree of adoption entered within one year from the institution of proceedings, unless extended by order of the court by reason of the special needs of the child provided the person adopting the child is Insured under the Policy on the date the adoption becomes effective.

Dependent eligibility expires concurrently with that of the Insured Student.

## HOW TO APPLY FOR COVERAGE

Argosy University/Western State University students have four plans to choose from. Please refer to the Schedule of Benefits in this booklet for a comparison of the four plans offered.

**TO ENROLL IN THIS COVERAGE, STUDENTS CAN LOG ONTO [WWW.AAI-TPA.COM](http://WWW.AAI-TPA.COM) AND FOLLOW THE INSTRUCTIONS.**

Effective dates are September 1, 2004; December 1, 2004; March 1, 2005 or June 1, 2005.

Deadline for enrollment is:

Annual . . . . . September 30, 2004  
Winter/Spring/Summer . . . . . December 31, 2004  
Spring/Summer . . . . . March 31, 2005  
Summer . . . . . June 30, 2005

***PLEASE NOTE: You will not be able to switch plans after your initial enrollment. Persons who select Plan C Base Plan may not switch to Plan C Major Medical. Once you have enrolled on a plan for the 2004/2005 school year you cannot change plans for the balance of the year (until September 1, 2005).***

## PREMIUMS

After initial enrollment, premiums will be billed quarterly:

<b>Quarterly Premiums</b>	<b>Student</b>	<b>Two Party</b>	<b>Family</b>
Plan A	\$635.00	\$1620.00	\$2273.00
Plan B	\$365.30	\$934.40	\$1308.15
Plan C Base Plan	\$123.00	\$446.00	\$597.00
Plan C Base with Major Medical	\$603.00	\$2189.00	\$2640.00

## PREMIUM PAYMENTS

After your initial enrollment in the plan, you will be billed for your next quarterly premium.

To avoid a lapse in coverage, your premium must be received by the due date. For example, if your due date is December 1, 2004, your premium must be received by December 1, 2004. If it is not received by that date, your coverage will be terminated paid to December 1, 2004.

## COVERAGE AFTER GRADUATION

Once you graduate you may continue coverage for one more quarter after graduation. For example: you are on the plan paid to June 1, 2005 and graduate in May. You can then continue your coverage for one more quarter from June 1 to September 1, 2005.

ANY QUESTIONS REGARDING ELIGIBILITY AND PREMIUM PAYMENTS SHOULD BE DIRECTED TO AAI at 1-800-770-6672.

## EFFECTIVE AND TERMINATION DATES

This Policy is a non-renewable one year term Policy. Enrollment in the plan is quarterly (3 months). The Eligible Student and their Eligible Dependents, may apply for coverage beginning September 1, 2004; December 1, 2004; March 1, 2005 or June 1, 2005, depending on when you begin classes.

The Master Policy on file at the University becomes effective at 12:01 a.m., September 1, 2004. Coverage becomes effective on that date or the date application and full premium are received by the Company (or it's authorized representative), whichever is later. The Master Policy terminates at 12:01 a.m., September 1, 2005. Coverage terminates on that date or at the end of the period through which premium is paid whichever is earlier.

## EXTENSION OF BENEFITS

If a Covered Person is hospital confined on the termination date from a covered Injury or Sickness for which benefits were paid before the termination date, covered medical expenses for such injury or Sickness will continue to be paid during hospital confinement as long as the confinement continues but not to exceed 12 months after the termination date. 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 benefits provided.

## NOTES

## PREFERRED PROVIDER INFO. (PLAN A & C ONLY)

Please read the following information so you will know from whom or what group of providers health care may be obtained.

Depending on which campus you attend, by enrolling in Plan A or Plan C With Major Medical, you have access to a Preferred Provider Network.

**Minnesota & Florida Campuses** have access to the Beech Street Preferred Provider Network. You may check their website at [www.beechstreet.com](http://www.beechstreet.com) or call 1-800-877-1444 for eligible providers who have contracted with the Beech Street Preferred Provider Network.



**All Other Campuses** have access to the CCN Preferred Provider Network. You may check their website at [www.ccnusa.com](http://www.ccnusa.com) or call 1-800-226-5116 for eligible providers who have contracted with the CCN Preferred Provider Network.



This enhancement to your program does not require you to use a Preferred Provider. You may receive care from any licensed provider (benefit eligibility is subject to the plan design and the exclusions and limitations as specified in the policy), but if you incur any expenses using a Preferred Provider, you will lower your out-of-pocket expense.

**"Preferred Allowances"** means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

**"Preferred Providers"** are the Doctors, hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.

**"Out of Network"** providers have not agreed to any prearranged fee schedules. You may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility.

The availability of specific providers is subject to change without notice. You should always confirm that a Preferred Provider is participating at the time services are required by asking the provider when you make an appointment for services.

# PLAN A

## PLAN A PRESCRIPTION DRUG BENEFIT

Your copay for prescriptions when purchased at a EBRx participating pharmacy is:

Plan A      \$25 Generic      \$50 Brand

**You have a \$500 maximum pharmacy benefit per policy (school) year.** The actual prescription charges (not the copay) will be applied to the pharmacy maximum.

**THERE IS NO BENEFIT FOR PRESCRIPTIONS IF NOT FILLED AT A PARTICIPATING EBRx MEMBER PHARMACY.**

Insured Persons will be given a combined medical and prescription ID Card to show to the pharmacy as proof of coverage. No claim forms need to be signed once you receive this ID Card. Until such card is received, you may fill your prescriptions at a participating pharmacy and obtain an itemized receipt. Once you receive your ID Card, if it is within 7-14 days from the time of purchase, you may take your card and receipt back to the pharmacy and they will reimburse you the full amount paid minus your applicable co-pay. If it is past your pharmacy return policy (usually 7-14 days), you will need to file a claim form, available online at [www.aai-tpa.com](http://www.aai-tpa.com).

**TO FIND A PARTICIPATING PHARMACY PLEASE CALL 1-800-800-7153 OR VISIT THE WEB SITE AT WWW.EBRX.COM**

Not all medications are payable. The following drugs will be considered for coverage subject to the exclusions (see Exclusions, page 24): Federal Legend Drugs, State Restricted Drugs and Compounded Medications. The amount of drug that is to be dispensed per prescription or refill will be in quantities prescribed up to a 30 day supply.

***The following drugs are excluded from coverage under this benefit:*** diaphragms, contraceptive jellies, creams, foams or devices, legend vitamins or food supplements, fertility medications, non-federal legend drugs, smoking deterrents, immunization agents, biological sera, therapeutic devices or appliances, drugs for hair growth (Rogaine) or for cosmetic purposes only (Renova), drugs labeled "Caution-limited by Federal Law to investigational use", experimental drugs, drugs for which no charge is made or drugs received as a patient in a licensed hospital or similar institution.

The Policy provides benefits for the Usual, Customary and Reasonable Charges (UCR) incurred by a Covered Person for loss due to a Medically Necessary covered Injury or Sickness, when not using a Preferred Provider. If you receive care from a Preferred Provider, any covered medical expense will be paid at the Preferred Allowance level of benefits, as listed below.

<b>SCHEDULE OF BENEFITS</b>		<b>PLAN A</b>	
Lifetime Aggregate Maximum		\$50,000	
Annual Deductible (Policy Year 9/1/04 - 8/31/05)		\$500 per person	
<b>INPATIENT BENEFITS</b>			
<b>There is a separate \$200 deductible per admission that must be paid before Inpatient Benefits can be utilized.</b>			
Inpatient Hospitalization (based on semi-private room rate).		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Intensive Care Unit Expense		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Doctor Hospital Visit Expenses		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
<b>INPATIENT SURGICAL BENEFITS</b>			
<b>All Inpatient Surgical Covered Medical Expenses in this section are subject to a \$5,000 per injury or sickness benefit maximum.</b>			
Surgical Expense, including surgeon and facility charge		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Anesthetist Expense		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Assistant Surgeon		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	

<b>SCHEDULE OF BENEFITS</b>		<b>PLAN A</b>	
<b>OUTPATIENT BENEFITS (INCLUDING OUTPATIENT SURGICAL)</b>			
<b>All Outpatient covered medical expenses in this section are subject to a \$5,000 per injury or sickness benefit maximum.</b>			
Doctor's Office Visits		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Physiotherapy/Physical Therapy/ Chiropractic Care		<i>In-Network: 70% of Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Laboratory Test / Diagnostic x-ray <b>(\$250 Maximum per Policy Year)</b>		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Durable Medical Equipment		50% of UCR	
<b>Emergency Room</b> In the event of a Medical Emergency, services rendered by any Hospital (In-Network or Out-of-Network) due to and within the first 24 hours after the onset of the Emergency are covered as if the services had been provided by a Preferred Hospital		<i>In-Network: 70% of the Preferred Allowance after \$50.00 copay (waived if admitted)</i> <i>Out-of-Network: 50% of UCR after additional \$50 deductible</i>	
Surgical Expense, including surgeon and facility charge		<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	

<b>SCHEDULE OF BENEFITS</b>		<b>PLAN A</b>
Anesthetist Expense	<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Assistant Surgeon	<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
<b>ADDITIONAL BENEFITS</b>		
Dental Benefit (payable only when accidental Injury to natural teeth).	<i>In-Network: 70% of the Preferred Allowance</i> <i>Out-of-Network: 50% of UCR</i>	
Ambulance Benefit	70% of UCR to or from a hospital when required due to a Medical Emergency up to \$350 maximum benefit.	
Home Health Care Benefit	100% of UCR up to a 40 visit maximum per policy year. Four hours of home health aide service shall be considered as one home care visit.	
Prescription Drugs	See page 5 for Pharmacy Benefit	
<b>MENTAL AND NERVOUS DISORDERS, SUBSTANCE ABUSE BENEFIT</b>		
Inpatient	Paid as any other Sickness Under Inpatient Benefits	
Outpatient - <b>Subject to a separate \$75 deductible, which will be applied to \$500 school year deductible.</b>	Up to \$50 per visit, 20 visits maximum per Policy year (school year)	

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# PLAN B

## PLAN B PRESCRIPTION DRUG BENEFIT

Your copay for prescriptions when purchased at a EBRx participating pharmacy is:

Plan B            \$5 Generic            \$10 Brand

### ***\$500 Maximum Benefit***

***The actual prescription charges (not the copay) will be applied to the pharmacy maximum. Prescriptions for mental and nervous disorders are also subject to the outpatient benefit maximums for mental and nervous disorders as described on page 17 as well as being applied to pharmacy maximum.***

**THERE IS NO BENEFIT FOR PRESCRIPTIONS IF NOT FILLED AT A PARTICIPATING EBRx MEMBER PHARMACY.**

Insured Persons will be given a combined medical and prescription ID Card to show to the pharmacy as proof of coverage. No claim forms need to be signed once you receive this ID Card. Until such card is received, you may fill your prescriptions at a participating pharmacy and obtain an itemized receipt. Once you receive your ID Card, if it is within 7-14 days from the time of purchase, you may take your card and receipt back to the pharmacy and they will reimburse you the full amount paid minus your applicable co-pay. If it is past your pharmacy return policy (usually 7-14 days), you will need to file a claim form, available by calling USI NW at 1-800-251-4246 or online at [www.aai-tpa.com](http://www.aai-tpa.com).

**TO FIND A PARTICIPATING PHARMACY PLEASE CALL 1-800-800-7153 OR VISIT THE WEB SITE AT [WWW.EBRX.COM](http://WWW.EBRX.COM)**

Not all medications are payable. The following drugs will be considered for coverage subject to the exclusions (see Exclusions, page 24): Federal Legend Drugs, State Restricted Drugs and Compounded Medications. The amount of drug that is to be dispensed per prescription or refill will be in quantities prescribed up to a 30 day supply.

***The following drugs are excluded from coverage under this benefit:*** acne treatments, allergy & asthma medications, birth control pills (except Texas), diaphragms, contraceptive jellies, creams, foams or devices, legend vitamins or food supplements, fertility medications, non-federal legend drugs, smoking deterrents, immunization agents, biological sera, therapeutic devices or appliances, drugs for hair growth (Rogaine) or for cosmetic purposes only (Renova), drugs labeled "Caution-limited by Federal Law to investigational use", experimental drugs, drugs for which no charge is made or drugs received as a patient in a licensed hospital or similar institution.

The Policy provides benefits for the Usual, Customary and Reasonable Charges (UCR) incurred by a Covered Person for loss due to a Medically Necessary covered Injury or Sickness.

SCHEDULE OF BENEFITS		PLAN B
Annual Deductible	None	
Maximum Benefit	\$25,000 Per Injury or Sickness Maximum	
<b>INPATIENT BENEFITS</b>		
Hospital Room and Board Expense	The hospital's daily semi-private room rate, or Intensive Care Unit Rate, if applicable, up to \$300 per day.	
Nurse Expense	For the services of a licensed registered or licensed practical nurse while hospital confined, up to \$100, not to exceed 5 days.	
Hospital Miscellaneous Expense	For x-ray examinations, laboratory tests, anesthesia, medicines, use of operating room, plaster casts, temporary surgical appliances, inclusive of pre-admission testing, when confined as a bed patient in a hospital, up to \$800 per day.	
Physiotherapy / Physical Therapy/Chiropractic	Limited to one visit per day. Up to a \$500 maximum benefit	
Anesthesia Expense	When surgery requires the services of an anesthetist not employed or retained by the hospital. Up to 25% of the amount payable for the surgical procedure	
Doctor's Visits Benefits limited to one visit per day and do not apply when related to surgery	Up to \$40 for the first day, \$20 for each subsequent day, not to exceed \$500.	

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SCHEDULE OF BENEFITS		PLAN B
Surgical Expense (In or Out of Hospital)	For surgery by a doctor, up to \$2,500 maximum	
<b>OUTPATIENT BENEFITS</b>		
Day Surgery Miscellaneous Hospital Expense (Ambulatory Surgical Centers)	For x-ray examinations, laboratory tests, anesthesia, medicines, use of operating room, plaster casts, temporary surgical appliances, inclusive of pre-admission testing. Up to \$500 per day maximum	
Doctor's Visits	For non-surgical or non-physiotherapy services, limited to one visit per day. Payable up to \$45 for the first visit, \$30 for each subsequent day, not to exceed \$225 maximum	
Physiotherapy / Physical Therapy / Chiropractic Limited to One Visit Per Day	Payable up to \$45 for the first day, \$30 for the second day, not to exceed 2 days	
Outpatient X-ray, Laboratory and Emergency Room Expense	For diagnostic x-ray and laboratory services including diagnostic procedures performed by a doctor on an outpatient basis under a doctor's instructions, and for treatment of a <b>Emergency Medical Condition</b> at a hospital outpatient department or emergency room. Payable up to \$500 maximum benefit	
<b>OTHER BENEFITS</b>		
Ambulance	A professional ground ambulance to or from a hospital when required due to the emergency nature of a sickness. Payable up to \$100 maximum benefit	
Consultant Doctor Fees When requested & approved by attending Doctor	Payable up to \$50	
Dental Expense	The expense for dental treatment for an accidental injury to sound, natural teeth. Up to \$100 per tooth	

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SCHEDULE OF BENEFITS		PLAN B
<b>MENTAL &amp; NERVOUS DISORDERS*</b>		
Inpatient Benefits	While hospital confined, benefits will be paid as any other Sickness. Not to exceed \$1,000 maximum per Policy (school) year	
Outpatient Benefits	Payable at 100% up to a maximum of 5 visits per policy (school) year; not per diagnosis/sickness	
<i>*All covered medical expenses incurred as a result of mental or nervous disorders are subject to the above stated maximums; if otherwise provided under the Policy, this includes items such as prescription drugs and diagnostic testing. No other benefits are provided for treatment of mental or nervous disorders. Psychiatric hospitals are not covered. Treatment of mental or nervous disorders must be administered by a Medical Doctor or licensed Psychologist, Ph.D.</i>		
Prescriptions	See page 9 for this benefit.	

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# PLAN C

## PLAN C PRESCRIPTION DRUG BENEFIT

Your copay for prescriptions when purchased at a EBRx participating pharmacy is:

Plan C Base: \$15 copay Generic \$30 copay Brand  
**\$100 Maximum Benefit**

Plan C Major Medical:

\$15 copay Generic \$30 copay Brand  
**\$500 Maximum Benefit**

***The actual prescription charges (not the copay) will be applied to the pharmacy maximum. Prescriptions for mental and nervous disorders are also subject to the outpatient benefit maximums for mental and nervous disorders as described on page 17 as well as being applied to pharmacy maximum.***

**THERE IS NO BENEFIT FOR PRESCRIPTIONS IF NOT FILLED AT A PARTICIPATING EBRx MEMBER PHARMACY.**

Insured Persons will be given a combined medical and prescription ID Card to show to the pharmacy as proof of coverage. No claim forms need to be signed once you receive this ID Card. Until such card is received, you may fill your prescriptions at a participating pharmacy and obtain an itemized receipt. Once you receive your ID Card, if it is within 7-14 days from the time of purchase, you may take your card and receipt back to the pharmacy and they will reimburse you the full amount paid minus your applicable co-pay. If it is past your pharmacy return policy (usually 7-14 days), you will need to file a claim form, available by calling USI NW at 1-800-251-4246 or online at [www.aai-tpa.com](http://www.aai-tpa.com).

**TO FIND A PARTICIPATING PHARMACY PLEASE CALL 1-800-800-7153 OR VISIT THE WEB SITE AT [WWW.EBRX.COM](http://WWW.EBRX.COM)**

Not all medications are payable. The following drugs will be considered for coverage subject to the exclusions (see Exclusions, page 24): Federal Legend Drugs, State Restricted Drugs and Compounded Medications. The amount of drug that is to be dispensed per prescription or refill will be in quantities prescribed up to a 30 day supply.

**The following drugs are excluded from coverage under this benefit:** acne treatments, allergy & asthma medications, birth control pills (except Texas), diaphragms, contraceptive jellies, creams, foams or devices, legend vitamins or food supplements, fertility medications, non-federal legend drugs, smoking deterrents, immunization agents, biological sera, therapeutic devices or appliances, drugs for hair growth (Rogaine) or for cosmetic purposes only (Renova), drugs labeled "Caution-limited by Federal Law to investigational use", experimental drugs, drugs for which no charge is made or drugs received as a patient in a licensed hospital or similar institution.

**SCHEDULE OF BENEFITS****PLAN C - Base Plan****Plan C - Major Medical**

PLEASE NOTE: To purchase Plan C - Major Medical, you must also purchase Plan C - Base Plan. Eligible expenses will be paid under the Base Plan first. When eligible expenses paid exceed the \$5,000 maximum per injury or sickness on the Base Plan, eligible expenses will be processed accordingly under the Major Medical Plan.

		<b>In Network</b>	<b>Out of Network</b>
Annual Deductible	None	\$200 per Policy (School Year)	
Maximum Benefit	Up to \$5000 per Injury/Sickness per School Year	\$100,000 Maximum Lifetime Benefit	
<b>INPATIENT BENEFITS</b>			
Hospital Room & Board Expense	80% of UCR up to 5 days	80% of Pref. Allowance	60% of UCR
Hospital Miscellaneous Expenses	80% of UCR up to 5 days	80% of Pref. Allowance	60% of UCR
Physical Therapy / Physiotherapy / Chiropractic Care	Payable under Doctor's visits	80% of Pref. Allowance	60% of UCR
Doctor's Visits	\$20 per day up to 5 days	80% of Pref. Allowance	60% of UCR
Mental Health Benefits	Paid as any other service	80% of Pref. Allowance	60% of UCR
<b>INPATIENT/OUTPATIENT SURGERY BENEFIT</b>			
Surgeon	50% of UCR	80% of Pref. Allowance	60% of UCR
Asst Surgeon Fees / Anesthetist Services	20% of Surgeon's Fees Payable	80% of Pref. Allowance	60% of UCR
Day Surgery Miscellaneous	80% of UCR	80% of Pref. Allowance	60% of UCR
<b>OUTPATIENT BENEFITS</b>			
Doctor's Visits	\$20 per day, 5 day maximum	80% of Pref. Allowance	60% of UCR
Physiotherapy/Physical Therapy/ Chiropractic Care	Payable under Doctor's Visits	80% of Pref. Allowance	60% of UCR
Emergency Services	80% of UCR	80% of Pref. Allowance	60% of UCR
Diagnostic XRay / Lab Services	Up to \$100 per Injury/Sickness	80% of Pref. Allowance	60% of UCR
Outpatient Mental Health Benefits	Paid under Doctor's visits. \$200 maximum per policy year	80% of Pref. Allowance	60% of UCR
<b>OTHER BENEFITS</b>			
Ambulance	Up to \$100 per Injury/Sickness	80% of Pref. Allowance	60% of UCR
Consultant Physician Fees	Up to \$25 per Injury/Sickness	80% of Pref. Allowance	60% of UCR
Dental Benefit (payable only due to accidental injury to natural teeth).	\$50 Per tooth. \$100 maximum per policy year	80% of Pref. Allowance	60% of UCR
Prescriptions	See Page 13 for benefits		

## ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT

**Accidental Death and Dismemberment Benefits** - If as a result of Injury, the Insured Student sustains any one of the following losses within 180 days of the date of the Covered Accident, benefits will be provided as follows:

<u>Loss</u>	
Life	\$5,000
Both hands or both feet or sight of both eyes or any two or more such Members	\$5,000
Any one such Member	\$2,500

Member means hand, foot or eye. "Loss of hand or foot" means complete severance through or above wrist or ankle joint. "Loss of sight" means the total permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. "Severance" means the complete separation and dismemberment of the part from the body.

## ADDITIONAL BENEFITS (ALL PLANS)

Additional Benefits are covered subject to policy benefits & limitations.

**Maternity** - Paid as any other sickness.

**Women's Preventive Health Services** - We will pay the Usual and Customary Expenses incurred for an annual gynecological examination, including pelvic examination and clinical breast examination and routine pap smears in accordance with the recommendation of the American College of Obstetricians and Gynecologists.

**Mammography Examination Expense** - Benefits will be paid for the Usual and Customary Expenses incurred for mammography examination every year for a female Covered Person 40 years of age and older or a mammogram for a female Covered Person under age 40 based upon a Doctor's recommendation.

**Childhood Immunization Benefits** - We will pay the Usual and Customary Expenses incurred for child immunizations, including the immunization agents, which, as determined by the Department of Health, conform to the standards of the Advisory Committee on Immunization Practices of the Centers for Disease Control, U.S. Department of Health and Human Services. These benefits are exempt from the Deductible Amount and Maximum Benefit Amount.

*(continued on next page)*

## ADDITIONAL BENEFITS (ALL PLANS) (CONT.)

**Alcohol Abuse and Dependency** - Inpatient detoxification limited to 7 days each admission, up to a lifetime maximum of 4 admissions. Non-hospital residential care: 30 days per year for residential care, limited to a lifetime maximum of 90 days. Outpatient care: 30 outpatient, full-session visits or equivalent partial visits per year, limited to a lifetime of 120 outpatient, full-session visits or equivalent partial visits. The 30 outpatient or partial hospitalization services per year may be exchanged on a two-to-one basis to secure up to 15 additional non-hospital, residential alcohol treatment days.

**Diabetes Equipment, Supplies and Outpatient Self-Management Training and Education, Including Medical Nutrition Therapy** - Usual, Customary and Reasonable Expenses incurred for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes. Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.

**Cost of Nutritional Supplements (Formulas) as Medically Necessary** - Usual, Customary and Reasonable Expenses incurred for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician.

**Well Child Care Visits** - Covered Medical Expenses include the following services for a covered dependent under age 18: a review and written record of the child's complete medical history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests. The above listed services and periodic visits shall be provided in accordance with prevailing medical standards consistent with the Recommendation for Preventative Pediatric Health Care of the American Academy of Pediatrics.

**Annual Ob-Gyn Examination and Pap Smear** - Covered under Primary Doctor office visit and Outpatient laboratory benefits.

**Mammography** - Coverage will be provided for one baseline mammogram for women between ages 35 and 40, and one annual mammogram for women ages 40 and older, or more frequently at the recommendation of a physician. Payable under x-ray benefit.

**Other Additional Benefits** - You may be eligible for other benefits based upon where your college is located. Call AAI at 1-800-770-6672 for more information.

## DEFINITIONS

1. **Coinsurance** means the percentage amount of covered expenses for which you are responsible for any medical service or supply. The coinsurance is shown in the Schedule. We will pay the remaining amount of covered expenses, subject to the maximum amount for specific services and the maximum benefit for all services.
2. **Complications of pregnancy** means:
  - a. Conditions whose diagnosis is distinct from but adversely affected or caused by pregnancy and which require a hospital stay (when pregnancy is not terminated). Such conditions include, but are not limited to, acute nephritis; nephrosis; cardiac decompensation; missed abortion; hyperemesis gravidarum; pre eclampsia; and similar conditions of comparable severity; or
  - b. Cesarean section; therapeutic abortion; ectopic pregnancy which is terminated; and spontaneous termination of a pregnancy during a period of gestation when a viable birth is not possible.

**Complications of pregnancy** do not include:

  - False labor;
  - Occasional spotting;
  - Doctor-prescribed rest during pregnancy;
  - Morning sickness; or
  - Similar conditions associated with a difficult pregnancy that are not classified as a complication of pregnancy.
3. **Covered expenses** means charges:
  - a. Not in excess of usual, reasonable and customary charge;
  - b. Not in excess of the maximum benefit amount payable per service as shown in the Schedule;
  - c. Made for medical services and supplies not excluded under the policy;
  - d. Made for services and supplies which are medically necessary; and
  - e. Made for medical services specifically included in the Schedule.
4. **Covered person** means you and your eligible spouse and dependents covered under the policy. The proper premium payment must be made to be covered under the policy.
5. **Deductible** means the amount of covered expenses paid on behalf of a covered person before benefits are payable under the policy. The deductible amount is shown in the Schedule.
6. **Dependent** means your unmarried child who:
  - a. Chiefly relies on you for support and maintenance; and

## DEFINITIONS (CONT'D.)

- b. Lives within the United States; and
  - c. Is within the following age groups unless otherwise shown in the Schedule:
    - 1) Under 19 years of age;
    - 2) 19 but less than 25 years of age and enrolled in a School as a full time student; or
    - 3) 19 or more years of age, and primarily supported by you and incapable of self sustaining employment by reason of mental or physical handicap. Proof of the child's condition and dependence must be submitted to us within 31 days after the date the child ceases to qualify as a dependent under (1) or (2) above. We may, from time to time, require proof of the continuation of such condition and dependence. After that, we may require proof no more than once a year.
- "Child"** can include stepchild, foster child, legally adopted child, a child of adoptive parents pending adoption proceedings, and natural child.
7. **Doctor** means a licensed practitioner of the healing arts acting within the scope of his license, including a certified nurse practitioner performing services within the lawful scope of nurse practitioner practice. Doctor does not include:
    - a. You;
    - b. Your spouse, dependent, parent, brother, or sister; or
    - c. A person who ordinarily resides with you.
  8. **Hospital** means an institution:
    - a. Operated pursuant to law;
    - b. Primarily and continuously engaged in providing medical care and treatment to sick and injured persons on an inpatient basis;
    - c. Under the supervision of a staff of doctors;
    - d. Providing 24 hour nursing service by or under the supervision of a graduate registered nurse, (R.N.);
    - e. With medical, diagnostic and treatment facilities, and with major surgical facilities;
      - 1) On its premises; or
      - 2) Available on a prearranged basis; and
    - f. Charging for its services.

**Hospital does not include a clinic or facility for:**

    - Convalescent, custodial, educational or nursing care;
    - The aged, drug addicts or alcoholics; or
    - Rehabilitation.

## DEFINITIONS (CONT'D.)

9. **Hospital stay** means a medically necessary overnight confinement in a hospital when room and board and general nursing care are provided and a per diem charge is made by the hospital.
10. **Injury** means bodily harm resulting, directly and independently of disease or bodily infirmity, from an accident. All injuries to the same person sustained in one accident, including all related conditions and recurring symptoms of injuries will be considered one injury.
11. **Intensive care** means:
- A specifically designated facility of the hospital that provides the highest level of medical care; and
  - Restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. It must be:
    - Permanently equipped with special life-saving equipment for the care of the critically ill or injured; and
    - Under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to the Intensive Care Unit.
- Intensive care** does not mean any of these step-down units:
- Progressive care;
  - Sub-acute intensive care;
  - Intermediate care units;
  - Private monitored rooms;
  - Observation units; or
  - Other facilities not meeting the standards for intensive care.
12. **Emergency Medical Conditions** means a medical condition that manifests itself by symptoms of sufficient severity including severe pain that a prudent layperson possessing an average knowledge of health and medicine would reasonable expect that failure to receive immediate medical attention would place the health of a person or fetus in the case of a pregnant woman, in serious jeopardy.
- Expenses incurred for hospital emergency room will be paid only for a sickness or injury fulfilling the above conditions. These expenses will not be paid for minor sickness or minor injuries.
13. **Medically necessary** means those services or supplies provided or prescribed by a hospital or doctor:
- Essential for the symptoms and diagnosis or

## DEFINITIONS (CONT'D.)

- treatment of the sickness or injury;
  - Provided for the diagnosis, or the direct care and treatment of the sickness or injury;
  - In accordance with the standards of good medical practice;
  - Not primarily for your convenience or that of your doctor; and
  - That are the most appropriate supply or level of service that can safely be provided.
14. **Natural teeth** means natural teeth or teeth where the major portion of the individual tooth is present, regardless of fillings or caps, and is not carious, abscessed, or defective.
15. **Nurse** means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).
16. **Participating institution** means the college or university you attend during your term of coverage.
17. **Physiotherapy** means any form of the following: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a doctor.
18. **Policyholder** means Education Management Corporation.
19. **Prescription** means any authorization, including authorized refills, issued by a doctor for dispensing medication for the purpose and in the amount specified.
20. **Prescription drug** means:
- A legend drug;
  - A compound medication when at least one ingredient is a prescription legend drug;
  - Any other drug which under applicable state law may only be dispensed by prescription, including injectable insulin; or
  - Drugs and medications dispensed by a licensed pharmacist that are not specifically excluded by other provisions applicable to this coverage.
21. **Primary insured** means you.
22. **Sickness** means illness or disease diagnosed during the term of coverage under the Policy for the covered person. Sickness includes pregnancy and complications of pregnancy. All related conditions and recurring symptoms of sickness will be considered one sickness.

## DEFINITIONS (CONT'D.)

23. **Term of coverage** means the period of coverage beginning with your Effective Date and ending upon completion of a trimester, semester or other measure of an academic session determined by the participating institution.
24. **Usual, reasonable and customary** means:
- a. Charges and fees for medical services or supplies that are the lesser of:
    1. The usual charge by the provider for the service or supply given; or
    2. The average charged for the service or supply in the area where service or supply is received; and
  - b. Treatment and medical service that is reasonable in relationship to the service or supply given and the severity of the condition. Usual, reasonable and customary charges are calculated using the national database of Ingenix, Inc., at the 90th percentile.

## EXCLUSIONS

No benefits will be paid for loss or expense caused by or resulting from:

1. Services and supplies furnished normally without charge by the participating institution's infirmary, its employees, or doctors who work for the participating institution.
2. Normal health checkups, preventive testing or treatment, screening exams or testing in the absence of injury; unless specifically provided for in the Schedule.
3. Eye examinations, prescriptions or fitting of eyeglasses and contact lenses, or other treatment for visual defects and problems, unless payable as a covered expense associated with a sickness or injury covered by the policy.
4. Hearing examinations or hearing aids, or other treatment for hearing defects and problems, unless payable as a covered expense associated with an injury covered by the policy.
5. Dental treatment, except as specifically provided for in the Schedule.
6. War or any act of war, declared or undeclared, or while in the armed forces of any country.

## EXCLUSIONS (CONT'D.)

7. Participation in a riot or civil disorder, commission of or attempt to commit a felony, or fighting, except in self-defense;
8. Intentionally self inflicted injury, suicide or any attempt thereat.
9. Injury of any covered person sustained while:
  - a. Participating in any school, professional or organized sports contest or competition, unless specifically listed in the Schedule;
  - b. Traveling to or from such sport, contest or competition as a participant; or
  - c. During participation in any practice or conditioning program for such sport, contest or competition.
10. Skydiving; parachuting or bungi-cord jumping, hang gliding, glider flying, parasailing, sail planing, or flight in any kind of aircraft, except while riding as passenger on a regularly scheduled flight of a commercial airline.
11. Treatment in a military or Veterans Hospital or a hospital contracted for or operated by a national government or its agency unless:
  - a. The services are rendered on an medical emergency basis; and
  - b. A legal liability exists for the charges made on behalf of a covered person for the services given in the absence of insurance.
12. Injury caused by, or resulting from, the use of alcohol, controlled substance, illegal drugs, or any drugs or medicines that are not taken in the dosage or for the purpose prescribed by the person's doctor.
13. Elective surgery and elective treatment, including but not limited to; acne (excluded Plans B & C Only); acupuncture; oral contraceptives (except Texas) (covered on Plan A only); birth control procedures supplies and devices; biofeedback-type services; breast implants; breast reduction; circumcision; cosmetic treatment or cosmetic surgery; deviated nasal septum, including submucous resection and/or other surgical correction thereof; family planning; infertility diagnosis or treatment; expenses incurred with sterilization or sterilization reversal, or vasectomy or vasectomy reversal; hair growth, replacement or removal, alopecia; impotence, organic or otherwise; learning disabilities, except for testing; nonmalignant warts, moles and lesions, unless for diagnostic purposes; obesity and any condition resulting therefrom (including hernia of any kind), except for Treatment of an underlying Covered Sickness; sexual reassignment surgery;

## EXCLUSIONS (CONT'D.)

skeletal irregularities of one or both jaws, including orthognathic and mandibular retrognathia and temporomandibular joint dysfunction (TMJ) (except in FL, TX, MN, and WA); sleep disorders, including testing thereof; smoking cessation; vitamins; antitoxins; and weight increase or reduction, except as required to correct an injury for which benefits are otherwise payable under the policy.

14. Any loss covered by state or federal workers' compensation law, employer's liability law, occupational disease law, or similar laws or act.
15. Braces and appliances, except as specifically provided for in the Schedule.
16. Replacement braces and appliances.
17. Assistant surgeon services, except as specifically provided for in the Schedule.
18. That part of medical expense payable by any automobile insurance policy without regard to fault.
19. Any accident where the covered person is the operator of a motor vehicle and does not possess a current and valid motor vehicle operator's license.
20. Preventive medicines, serums, vaccines.
21. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan.
22. Rest cures or custodial care.
23. Personal services such as television and telephone or transportation.
24. Injury caused by or resulting from being legally intoxicated or to the blood alcohol level which is not less than the intoxication level under state law, controlled substance, illegal drugs or any drugs or medicines that are not taken in the dosage or for the person prescribed by the person's Doctor.

## HOW TO FILE A CLAIM

If a Medical Emergency, call 911 or report to the nearest emergency room.

In the event of an Injury or Sickness, the Covered Person should:

1. Consult a Doctor or Health Care Provider.
2. For all services, a Company claim form is required for filing a claim. You may secure a Company claim form by contacting AAI at 1-800-770-6672 or online at [www.aai-tpa.com](http://www.aai-tpa.com). Each Injury or Sickness is a separate condition and requires a separate claim form.
3. Fill in the necessary information and present it to the Doctor or Hospital rendering the service for diagnosis and itemized statement. Send all claim forms along with itemized Hospital and medical bills to:

**Associated Administrators, Inc.**  
**P.O. Box 5096**  
**Portland, OR 97208**  
**1-800-770-6672 Toll Free**

4. Written proof of loss must be furnished to the Company within 90 days after the date of loss. Failure to furnish proof within the time required will not invalidate nor reduce any claim if it is not reasonably possible to give proof within 90 days, provided the proof is furnished as soon as reasonably possible. However, except in the absence of legal capacity of the claimant, the proof may not be furnished later than one year from the date when the proof was originally required.

You have the right to request an independent medical review if Health Care Services has been improperly denied, modified, or delayed based on medical necessity.

### **SUBROGATION**

The Company shall be fully and completely subrogated, unless otherwise prohibited by law, to the rights of the Covered Person against parties who may be liable to provide indemnity or make a contribution in respect to any matter that is the subject of a claim under the Policy.

## MEDICAL EVACUATION AND REPATRIATION BENEFIT

(INTERNATIONAL STUDENTS AND THEIR DEPENDENTS ONLY)  
Plan C Only

When hospital confined for at least 5 consecutive days, and recommended and approved by the attending physician and claim office, benefits will be paid up to \$10,000 for the evacuation of the Covered Person to their home country.



A medical evacuation would be considered only if medically necessary and after a hospitalization of at least five (5) days.

If the Covered Person dies while insured under the Policy, benefits will be paid for the necessary expense for preparing and transporting the remains of the deceased person's body to his or her home country, up to \$7,500. Argosy University's Administration must approve any payments of repatriation expense.

This benefit does not include the transportation expense of anyone accompanying the body.

## NOTES

BELOW IS AN IDENTIFICATION CARD FOR YOUR USE.

	Claims Administered by: <b>ASSOCIATED ADMINISTRATORS, INC.</b> PO BOX 5096 PORTLAND, OR 97208 1-800-770-6672	
Insured _____		
Student of Argosy University/Western State University STUDENT HEALTH INSURANCE PLAN 2004-2005 Underwritten by: TIG PREMIER Group No. TP SI0001 Both the effective and termination dates of coverage are subject to verification by the Company. Preferred Providers: Beechstreet - MN & FL campuses CCN - All other campuses		

Underwritten and Insured by:  
**TIG PREMIER INSURANCE COMPANY**  
 Tinton Falls, NJ

For Benefits, Eligibility or Claim Inquiries  
 Contact:

**Associated Administrators, Inc.**  
**PO Box 5096**  
**Portland, OR 97208**

**Customer Service 1-800-770-6672**

You may print claim forms, ID cards and brochures  
 from [www.aai-tpa.com](http://www.aai-tpa.com).

FOR ALL OTHER QUESTIONS PLEASE CALL:

Managing Consultants:

### USI NW

Rico Bocala  
 Patricia Wylie  
 Brysis Boyd  
 Portland, Oregon  
 1-800-251-4246

**Students in the Chicago Area Call:**  
**GERALDINE H. FIELD**  
**THE FIELD GROUP**  
**CHICAGO, ILLINOIS**  
**1-800-949-3969**

A Partner Company  Insurance Services Corp.

### Important Notice:

This brochure describes the important features of Accident and Sickness Policy No. 18011. Please be sure to retain this brochure, as it outlines the provisions of the master policy which is on file at the Student Services office. No individual policies or certificates are issued. Any discrepancy between this brochure and the Master Policy, the Master Policy will prevail.

Revised 8/04

<b>EBRx</b>	
Customer Service:	1-888-274-6214
Visit website @	<a href="http://www.ebrx.com">www.ebrx.com</a>
Pharmacy Helpline	1-800-406-0015
Member/SS#:	
Group Number: AAI AR04	
For Pharmacy Use Only: EBRx BIN# 610560, MedECarrier#95	
<b>RULES GOVERNING USE OF THIS CARD</b>	
1) This card is not transferable and remains the property of EBRx. 2) Improper or fraudulent use of this card to obtain prescription drugs is punishable by law. 3) This card is void when your eligibility terminates. 4) The loss of this card should be reported immediately to your plan administrator.	