

**STUDENT  
HEALTH  
INSURANCE  
PLAN  
2005-2006**



**GEORGE FOX  
UNIVERSITY**

**Designed especially for students of  
GEORGE FOX UNIVERSITY  
Newberg, Oregon  
Policy No. 18027**

**Insured by:  
Fairmont Premier Insurance Company  
Tinton Falls, New Jersey**

**Claims Administered by:  
Personal Insurance Administrators, Inc.  
Agoura Hills, California**

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**Important Notice:** Please be sure to retain this brochure as it outlines the provisions of the Policy #18027, which is on file at the GFU Health and Counseling Center. This brochure is only a summary of a master insurance policy (the Master Policy) issued to the Policyholder by the Company. The Master Policy contains language and provisions not contained in this brochure. In the event of a conflict between this brochure and the master policy, the Master Policy will govern. No individual policies or certificates are issued.

The Policyholder requires its students (all full-time undergraduates and graduate students) to carry medical insurance coverage. This coverage must be accepted by the student unless proof of other coverage is provided.

# ELIGIBILITY

**ALL FULL-TIME UNDERGRADUATE & GRADUATE STUDENTS** of George Fox University are required to have insurance coverage. Any student with existing health insurance coverage may be exempted from participation in the student group plan by completing and filing a waiver form each academic year. Waiver forms for this purpose are available in the summer mailings and in the Student Accounts office.

## EFFECTIVE DATES & PREMIUMS

### STUDENT RATE:

	<u>PREMIUM</u>	<u>EFFECTIVE DATES</u>
<b>ANNUAL</b>	<b>\$1,055.00</b>	<b>8/16/05 – 8/15/06</b>
<b>SPRING</b>	<b>\$632.00</b>	<b>1/9/06 – 8/15/06</b>
<b>MASTERS OF ART IN TEACHING STUDENTS (MAT)</b>		
<b>ANNUAL</b>	<b>\$1,055.00</b>	<b>6/13/05 – 6/12/06</b>

Provided an enrollment form is correctly completed and proper premium is timely received, an Eligible Student becomes an Insured Individual on the first day of the school term for which coverage is applied for or, if different, the effective date required by the Policyholder for all similarly situated eligible persons.

Premiums will not be pro-rated.

Refunds of premium are allowed only upon entry into the armed forces.

Coverage will automatically terminate on the earliest of:

- A. The date of policy terminates;
- B. The last day of the period for which premium has been timely paid according to the policy provisions;
- C. The date the Insured Individual is no longer eligible for coverage.

## **CERTIFICATE OF CREDITABLE COVERAGE**

When your coverage terminates, you can request a Certificate of Creditable Coverage, which is evidence of your coverage under this policy. You may need such a certificate if you become covered under a group policy or other health plan within 63 days after your coverage under this policy terminates. If the subsequent policy excludes or limits coverage for medical conditions you have before you enroll, this Certificate may be used to reduce or eliminate those exclusions or limitations.

To obtain a Certificate of Creditable Coverage, please contact USI NW at 1-800-251-4246.

## **PRIVACY POLICY**

We know that your privacy is important to you and we strive to protect the confidentiality of your non public personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a detailed copy of our privacy policy by call PIA at 1-800-468-4343.

## **MEDEX TRAVEL ASSISTANCE**

The George Fox University student medical plan also includes a travel assistance plan through MEDEX Assistance Corporation.

This plan offers a comprehensive range of local and worldwide travel assistance that provides emergency medical assistance and non-medical travel assistance.

Some of the services provided to you under the MEDEX Assistance plan include emergency medical evacuation, repatriation, transportation arrangements, prescription drug assistance, translator services, bail-bond and baggage assistance. These services are available 24 hours a day anywhere in the world, even at your school, if you are more than 100 miles away from your place of permanent residence.

You can print a plan brochure and identification card specifically for the MEDEX Assistance plan at [www.piaclaims.com](http://www.piaclaims.com).

A toll-free or collect call immediately links you to MEDEX's highly trained, multilingual assistance coordinators, 24 hours a day, 365 days a year.

**1-800-537-2029 or 1-410-453-6330**

**[www.medexassist.com](http://www.medexassist.com)**

**Group No. 7274**

# PREFERRED PROVIDER INFORMATION

By enrolling in George Fox University Student Health Insurance Plan you have access to Preferred Provider networks.

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

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 expense using a Preferred Provider you will lower your out-of-pocket expense.

**IN OREGON** the preferred provider network is HC Direct. You may check for HC Direct Preferred Providers on the HC Direct Network by calling 1-877-287-2922 or at [www.hcdirect.net](http://www.hcdirect.net).



**OUTSIDE OF OREGON** preferred provider network is CCN. You may check for CCN Preferred Providers by calling 1-800-226-5116 or at [www.ccnusa.com](http://www.ccnusa.com).



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

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 checking the Preferred Provider Network website or calling the Preferred Provider Network and by asking the provider when you make an appointment for services.

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

**“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.

**“Allowable Charges”** means Fairmont Premier’s allowance for a specified Covered Medical Expense of the Provider’s charge for the service, whichever is less.

# MEDICAL EXPENSE BENEFITS

**The George Fox University Student Health Plan is Primary Coverage. It is designed to give protection against substantial loss because of Sickness or Injury.**

**The maximum benefit per Insured is \$50,000 per Injury or Sickness.**

## **Copayments and Coinsurance:**

**A. FOR CHARGES FROM A DOCTOR**, Covered Expenses will be paid at:

1. 90% without application of a copayment for services provided to an Insured Individual at George Fox University Health and Counseling Center.
2. 90% of preferred allowance after the Insured Individual pays a \$20 copayment per visit for services provided by a Preferred Provider Doctor (Refer to page 5 for Preferred Provider Network information).
3. 70% after a \$20 deductible per visit for services provided by a Doctor who is not a Preferred Provider.

**B. FOR CHARGES INCURRED AT AN EMERGENCY ROOM**, Covered Expenses will be paid at:

1. 90% of preferred allowance after the Insured Individual pays a \$100 copayment per visit (waived if admitted) for services provided by an emergency room that is a Preferred Provider (Refer to page 5 for Preferred Provider information).
2. 70% of UCR after a \$100 deductible per visit (waived if admitted for services provided by an emergency room which is not a preferred provider).

**C. FOR CHARGES INCURRED AT A HOSPITAL (INCLUDING INPATIENT & OUTPATIENT SERVICES, EXCEPT EMERGENCY ROOM)**, Covered Expenses will be paid at:

1. 90% of preferred allowance after the Insured Individual pays a \$50 copayment per admission or outpatient visit for services provided by a hospital that is a Preferred Provider (Refer to page 5 for Preferred Provider Network information).
2. 70% of UCR after a \$50 deductible per admission or outpatient visit for services provided by a hospital which is not a preferred provider.

**Subject to the exclusions, limitations, and all other provisions of the policy, benefits are payable as stated above for a Covered Expense if: (1) the copayment or deductible requirement is met; (2) the expense is incurred due to a covered Injury or Sickness; and (3) the Insured Individual has not exceeded the Major Medical maximum for the Injury or Sickness for which the expense is incurred.**

If it is not reasonably possible to get to a Preferred Provider for care, such as if the Insured Individual is out of the Preferred Provider's service area, benefits will be payable at the Preferred Provider level, subject to UCR, after a \$50 deductible at a Hospital, \$100 deductible at an emergency room or \$20 deductible per doctor visit.

**Please refer to page 5 for Preferred Provider Network information and the networks available to students Insured on this plan.**

## **OUT OF POCKET EXPENSE MAXIMUM**

When \$2,000 of Out-of-Pocket Expenses has been paid by an Insured Individual during a school year, the level of benefit payments, if otherwise applicable, will automatically increase to 100% for additional Covered Expenses incurred by that Insured Individual during the remainder of that school year, and copayment or deductible charges will no longer apply. An Out-of-Pocket Expense is the 10% PPO/30% Non-PPO share of any otherwise Covered Expense and copayment or deductible amounts which an Insured Individual pays (subject to policy maximums, limitations & exclusions).

## **COVERED EXPENSES**

**SUBJECT TO THE POLICY BENEFITS, EXCLUSIONS, LIMITATIONS AND ALL OTHER POLICY PROVISIONS**, Covered Expenses under the policy are limited to the following types of expenses prescribed by a Doctor for therapeutic treatment of a covered Injury of Sickness:

- A. Charges for diagnosis and treatment by a Doctor, as defined;
- B. Charges for daily Hospital room and board or intensive care unit charges not exceeding the Preferred Provider's Allowance or 70% of Hospital's Average Semi-private charge;
- C. Charges by a Hospital for medical care received on an outpatient basis and outpatient medical supplies used on the premises of a Hospital;
- D. Charges for laboratory, x-ray and other diagnostic examinations;
- E. Charges for prescription drugs required to be dispensed by a licensed pharmacist, except the policy will pay 90% of charges for such drugs used on an inpatient at a PPO Hospital and 70% for such drugs used at a non-PPO Hospital and 50% of charges for brand name drugs or 80% for generic used for outpatient treatment;
- F. Charges for emergency professional ambulance service by ground or air to a Hospital will be paid directly to the provider or jointly to the provider and the Insured Individual;

## COVERED EXPENSES CONTINUED.....

G. Charges for the following listed types of orthopedic or prosthetic devices or Hospital equipment:

1. man-made limbs or eyes for replacing of natural limbs or eyes;
2. casts, splints or crutches;
3. purchase of a truss or brace;
4. oxygen and rental of equipment of giving oxygen;
5. rental of a wheelchair or hospital bed;
6. rental of dialysis equipment supplies;
7. colostomy bags and ureterostomy bags;
8. two external post-operative breast prosthesis.

The policy will not cover rental charges for equipment in excess of the purchase price of the equipment.

H. Covered expenses will include services of a home health care provider under a home health care plan. The maximum number of visits payable will not exceed 90 visits in any 12 consecutive month period. Up to 4 consecutive hours in a 24-hour period of home health care service are considered as one home health care visit.

I. Charges for an annual mammogram for women over 40, or more frequently if recommended by a Doctor, and an annual breast, pelvic and pap smear for women age 18 and over, or more frequently based on a Doctor's recommendation.

J. Non prescription elemental enteral formula for home use if:

1. formula is medically necessary for treatment of severe intestinal malabsorption;
2. doctor wrote an order for the formula;
3. formula comprises the sole source (essential) of nutrition.

K. Immunizations to a maximum benefit per school year of \$250.00.

L. Charges for diagnostic testing for learning disabilities. However, treatment for diagnostic testing for learning disabilities is not a standard covered expense. **STUDENTS MUST BE REFERRED BY THE HEALTH AND COUNSELING CENTER (HCC) AT GEORGE FOX UNIVERSITY TO BE ELIGIBLE FOR THIS BENEFIT.**

M. Diabetes self-management and education: Coverage for diabetes self-management is payable at 75% of the cost of the education program or \$120.00 whichever is the lesser, regardless of the deductible and coinsurance benefits applicable to other benefits under the policy.

N. Charges for Chiropractic Care will be payable as follows: The office visit will be paid as any other Doctor visit, see page 2, The manipulation will be paid as Physiotherapy, see below.

O. Charges for Physiotherapy which are incurred while not confined in a Hospital and which are billed by a Doctor or physiotherapist, are payable up to \$50.00 maximum per visit, limited to a maximum benefit of \$1,000.00 per policy year (school year).

## COVERED EXPENSES CONTINUED.....

- P. Covered Expenses for pregnancy are payable on the same basis as Covered Expenses for any other Sickness with respect to any insured female.

Pregnancy coverage also includes inpatient Hospital care following delivery in accordance with the guidelines recommended by the American Academy of Pediatrics and the American College of OB/GYN's.

A decision to shorten the length of inpatient Hospital stay following childbirth to less than what is recommended must be made by the attending Doctor. If such a decision is made, pregnancy coverage shall also include coverage for one At-Home Post-Delivery Care visit, provided the visit will occur within 48 hours following the discharge of the mother and her newborn Child from the Hospital. However, at the mother's discretion, the visit may occur at the facility of the provider. A newborn child of an Insured Student will automatically be an Insured Individual for 31 days from the moment of its birth for Covered Expenses incurred which are due directly to Injury or Sickness, premature birth, or a congenital condition which exists at birth.

- Q. Covered expenses for inpatient treatment of a Mental or Nervous Disorder or Substance Abuse up to aggregate limit of 3 days of inpatient care per school year. Outpatient treatment will be subject to a maximum number of outpatient visits of 10 per school year. **STUDENTS SHOULD SEEK REFERRAL BY THE HEALTH AND COUNSELING CENTER (HCC) AT GEORGE FOX UNIVERSITY FOR THE MENTAL AND NERVOUS BENEFITS.**

- R. Outpatient prescription drug charges, required to be dispensed by a licensed pharmacist, will be paid at 50% for any brand name drug or at 80% for generic.

You may purchase your prescription at any pharmacy. After your purchase you must submit the itemized prescription receipt along with a claim form to PIA for reimbursement.

## EXTENSION OF BENEFITS

Benefits will still be payable up to a maximum benefit of \$5,000.00 or 13 weeks, whichever comes first, (subject to policy maximums and limitations) for a covered Injury or Sickness for which an Insured Individual has a continuing claim on the date the Individual's insurance terminates. Such benefits terminate if the Insured Individual becomes covered for the Injury or Sickness, for which benefits were continued, under any other medical coverage. However, if the Insured Individual is a registered bed-patient in a Hospital when the policy ends and the policy is immediately replaced by another group plan, Benefits will continue for the Insured Individual until the earliest of the following:

1. the date inpatient Hospital confinement ends; or
2. the Hospital benefits under the policy are exhausted.

## PRE-EXISTING CONDITION LIMITATIONS

**Pre-existing Conditions** are not covered for a period of six months after the Effective Date of coverage. Pre-existing conditions means a condition for which medical advice, diagnosis, care or treatment was recommended or received during the six months prior to the Effective Date of coverage. Genetic information does not constitute a pre-existing condition in the absence of a diagnosis of the condition related to such information. This pre-existing condition limitation does not apply to a newborn child or adopted child. Credit will be given for the time an insured is covered under a Qualifying Prior Coverage if the coverage was in force within 63 days prior to the effective date of this coverage in force with the school. The student is permitted to have a one term or semester break without restarting the pre-existing condition period. "Qualifying Prior Coverage" means any individual or group policy, contract, or program that is underwritten or administered by an insurer, nonprofit hospital service plan, care service plan, fraternal society, self-insured employer plan, or other type of entity that provides or arranges medical, hospital and surgical coverage, which does not supplement other private or governmental plans. This includes continuation or conversion coverage, but does not include accident-only, credit, disability income, Medicare Supplement, long term care, dental, vision, worker's compensation or similar law, or any other publicly sponsored health program.

# 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.
4. Copayment means the dollar amount that a covered person pays directly to a doctor, hospital or other health care provider at the time a covered service is rendered.
5. **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.
6. **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.
7. **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.

## DEFINITIONS CONTINUED.....

8. **Dependent** means your unmarried child who:
- a. Chiefly relies on you for support and maintenance; and
  - 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.

8. **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** includes a physician assistant licensed under ORS 655.515(4) when acting with the scope of his license. **Doctor** shall include a Clinical Social Worker licensed under ORS 675.510 to 675.600.

**Doctor** does not include:

- a. You;
  - b. Your **spouse, dependent**, parent, brother, or sister; or
  - c. A person who ordinarily resides with you.
9. **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** includes a hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program.

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

- Convalescent, custodial, educational or nursing care;
  - The aged, drug addicts or alcoholics; or
  - Rehabilitation.
10. **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**.

## DEFINITIONS CONTINUED.....

11. **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**.

12. **Intensive care** means:

- a. A specifically designated facility of the **hospital** that provides the highest level of medical care; and
- b. 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:

- (i) Permanently equipped with special life-saving equipment for the care of the critically ill or injured; and
- (ii) 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**:

- a. Essential for the symptoms and diagnosis or treatment of the **sickness** or **injury**;
- b. Provided for the diagnosis, or the direct care and treatment of the **sickness** or **injury**;
- c. In accordance with the standards of good medical practice;
- d. Not primarily for your convenience or that of your **doctor**; and
- e. 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.

16. **Nurse** means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

17. **Participating institution** means the college or university you attend during your **term of coverage**.

## DEFINITIONS CONTINUED.....

18. **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**.
19. **Policyholder** means George Fox University.
21. **Prescription** means any authorization, including authorized refills, issued by a **doctor** for dispensing medication for the purpose and in the amount specified.
22. **Prescription drug** means:
- a. A legend drug;
  - b. A compound medication when at least one ingredient is a prescription legend drug;
  - c. Any other drug which under applicable state law may only be dispensed by **prescription**, including injectable insulin; or
  - d. Drugs and medications dispensed by a licensed pharmacist that are not specifically excluded by other provisions applicable to this coverage.
23. **Primary insured** means you.
24. **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**.
25. **Spouse** means your lawful **spouse**.
26. **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**.
27. **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 90<sup>th</sup> percentile.

## EXCLUSIONS AND LIMITATIONS

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

1. Any **Sickness**, as defined, that was initially diagnosed, treated or recommended for treatment prior to the Term of Coverage for a Covered Person, unless continuous coverage is applied.
2. Services and supplies furnished normally without charge by the **participating institution's** infirmary, its employees, or **doctors** who work for the **participating institution**
3. Services covered or provided by the student health fee.
4. Normal health checkups, preventive testing or treatment, screening exams or testing in the absence of injury; unless specifically provided for in the Schedule.
5. 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.
6. 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.
7. Dental treatment, except as specifically provided for in the Schedule.
8. War or any act of war, declared or undeclared, or while in the armed forces of any country.
9. Participation in a riot or civil disorder, commission of or attempt to commit a felony, or fighting, except in self-defense;
10. Intentionally self-inflicted **injury**, suicide or any attempt thereat.
11. **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.
12. 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.
13. 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.

## EXCLUSIONS CONTINUED.....

14. **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 purpose prescribed by the person's **doctor**.
15. Elective surgery and elective treatment, including but not limited to; acupuncture; birth control, including surgical procedures 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; elective abortion; family planning; 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; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia and temporomandibular joint dysfunction (TMJ); 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.
16. Any loss covered by state or federal worker's compensation law, employers liability law, occupational disease law, or similar laws or act.
17. Braces and appliances, except as specifically provided for in the Schedule.
18. Replacement braces and appliances.
19. That part of medical expense payable by any automobile insurance policy without regard to fault.
20. 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, except while in a Driver's Education Program.
21. Preventive medicines, serums, vaccines, except as specifically provided for in the Schedule.
22. Expenses to the extent that they are paid or payable under other valid and collectible group insurance or medical prepayment plan.
23. Rest cures or custodial care.
24. Personal services such as television and telephone or transportation.

## **EXAMPLE: HOW BENEFITS ARE PAID**

Preferred Providers are the Doctors, hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. By enrolling in this insurance program you have access to H C Direct Preferred Provider Network in Oregon. You may search for participating providers at [www.hcdirect.net](http://www.hcdirect.net) or by calling 1-877-287-2922.

Outside of Oregon the Preferred Provider Network is CCN. You may search for participating providers on the CCN network at [www.ccnusa.com](http://www.ccnusa.com) or by calling 1-800-226-5116.

Facilities and professional providers that do not have a preferred or participating contract (non-network or out-of-network) may bill for any balances over the payment level. You may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility.

### **Participating Network Provider Benefits**

Usual and Customary Charges (Billed)	\$1,000.00
Contracted amount for Network Providers (20% Discount)*	800.00
<b>Less Your Copay (for charges by a doctor)**</b>	<b>-20.00</b>
Eligible Benefit Amount	\$780.00
Plan pays 90% of Eligible Benefit Amount	<b>\$702.00</b>
<b>10% Coinsurance (You Pay)</b>	<b>\$78.00</b>
<b>TOTAL AMOUNT YOU PAY (\$20 copay + \$78.00 coinsurance)</b>	<b>\$98.00</b>

### **Non-Network Provider Benefits**

Usual and Customary Charges (Billed)	\$1,000.00
<b>Less Your Copay (for charges by a doctor)**</b>	<b>-20.00</b>
Eligible Benefit Amount	\$980.00
Plan pays 70% of Eligible Benefit Amount	<b>\$686.00</b>
<b>30% Coinsurance (You Pay)</b>	<b>\$294.00</b>
<b>TOTAL AMOUNT YOU PAY (\$20 copay &amp; \$294.00 coinsurance)</b>	<b>\$314.00</b>

### **Non-Network Provider Benefits – Billed at Over Usual & Customary Rate**

Billed at Over Usual & Customary (UCR is \$1,000)	\$1,200.00
<b>Benefit Not Payable by Plan (You Pay)</b>	<b>-200.00</b>
Less Your Copay (for charges from a doctor)**	-20.00
<b>Eligible Benefit Amount</b>	<b>\$980.00</b>
Plan pays 70% of Eligible Benefit Amount	\$686.00
30% Coinsurance (You Pay)	\$294.00
<b>TOTAL AMOUNT YOU PAY (\$200 + \$20 copay + \$294 coinsurance)</b>	<b>\$514.00</b>

\* The discounts shown are for illustrative purposes only.

\*\* Example based on charges from a doctor (refer to page 6 of the plan brochure for explanation of copays and coinsurance).

## HOW TO FILE A CLAIM

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

1) Report to the George Fox University Health & Counseling Center (HCC) for treatment or when not in school, to a Physician or Hospital.

IN THE EVENT OF AN EMERGENCY CALL 911 OR REPORT TO THE NEAREST EMERGENCY ROOM.

2) Obtain a claim form from the Health & Counseling Center or print one at [www.piaclaims.com](http://www.piaclaims.com).

3) The completed claim form and all hospital and medical bills must be submitted within 30 days of Injury or first treatment for a Sickness. The Company should receive bills within 90 days of service. In no event, except in the absence of legal capacity, will a claim be honored later than twelve months from the date when the proof was originally required.

**4) SEND CLAIM FORM ALONG WITH ITEMIZED HOSPITAL AND MEDICAL BILLS TO:**

**PERSONAL INSURANCE  
ADMINISTRATORS, INC.  
P. O. BOX 6040  
AGOURA HILLS CA 91376-6040**

**CUSTOMER SERVICE  
1-800-468-4343  
[WWW.PIACLAIMS.COM](http://WWW.PIACLAIMS.COM)**

## SUBROGATION

If we have paid benefits for a Covered Person for Injuries received in a covered Accident, and in our opinion a third party may be liable, we will be subrogated to the extent of such payment and to all of the rights of the Covered Person regarding the recovery of benefits paid or any of settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers to do whatever else is necessary to transfer his rights to us. We will exercise such rights on his behalf, he further agrees to furnish us with all relevant information and documents.

**PLAN IS UNDERWRITTEN BY:**

FAIRMONT PREMIER INSURANCE COMPANY  
TINTON FALLS N.J.

**CLAIMS ADMINISTERED BY:**

PERSONAL INSURANCE ADMINISTRATORS, INC.  
P O BOX 6040  
AGOURA HILLS CA 91376-6040  
1-800-468-4343  
[WWW.PIACLAIMS.COM](http://WWW.PIACLAIMS.COM)

**WRITING AGENT:**

USI NW  
RICO BOCALA  
PATRICIA WYLIE  
BRYDIS BOYD  
PORTLAND, OR  
1-800-251-4246

**STUDENT TRAVEL ASSISTANCE**

MEDEX ASSISTANCE CORPORATION  
BALTIMORE, MD  
INSIDE U.S. CALL 1-800-527-0218  
OUTSIDE U.S. CALL COLLECT 1-410-453-4330  
MEDEX GROUP NUMBER 7274

**PREFERRED PROVIDER NETWORKS**

**IN OREGON:**

H C DIRECT  
1-877-287-2922  
[www.hcdirect.net](http://www.hcdirect.net)

**OUTSIDE OF OREGON:**

CCN  
1-800-226-5516  
[www.ccnusa.com](http://www.ccnusa.com)

<p style="text-align: center;">Administered by:  <b>PERSONAL INSURANCE ADMINISTRATORS, INC.</b>          Insured _____          Student of  <b>GEORGE FOX UNIVERSITY</b>  <b>2005-2006 Student Insurance Plan</b></p> <p style="text-align: center;">Insured by:  <b>FAIRMONT PREMIER INSURANCE COMPANY</b>          Policy No. 18027</p> <p style="text-align: center;">NOTE: benefits are subject to payment of appropriate premium and verification of eligibility.</p>	<p style="text-align: center;"><b>Submit All Claims or Inquiries to:</b>  <b>PERSONAL INSURANCE ADMINISTRATORS, INC.</b>          P.O. Box 6040 • Agoura Hills, CA 91376-6040          For benefits and eligibility call: 1-800-468-4343</p> <p style="text-align: center;"><b>For Participating Providers In Oregon</b>          Call 1-503-786-4697 or          Visit the HC Direct website: <a href="http://www.hcdirect.net">www.hcdirect.net</a></p> <p style="text-align: center;"><b>For Providers Outside of Oregon</b>          Call 1-800-226-5116 or          Visit the CCN website: <a href="http://www.ccnusa.com">www.ccnusa.com</a></p> <p style="text-align: center;">To utilize <i>travel assistance</i> through <b>MEDEX Assistance Corporation</b>,          please call 1-800-527-0218 or 1-410-453-4330 collect from outside          the U.S.A. and identify your group as <b>7274</b>.</p>
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ABOVE IS AN IDENTIFICATION CARD.

PLEASE CUT OUT THIS CARD, FOLD IN HALF AND CARRY WITH YOU.