

**STUDENT
HEALTH
INSURANCE
PLAN
2005-2006**



**designed especially for
students of
UNIVERSITY OF PORTLAND
Portland, Oregon**

Policy #: 18021

Claims Administered by
Personal Insurance Administrators, Inc.
Agoura Hills, CA

BR UP05

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PRIVACY POLICY

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information.

We do not disclose any nonpublic personal information about our 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 calling **PIA** toll-free at **1-800-468-4343**.

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.

ELIGIBILITY

ALL FULL-TIME STUDENTS of the University of Portland taking 12 hours or more are eligible to participate in this plan and will be billed for premium each semester during the regular academic year. Any student with existing health coverage may be exempted from participation in the University's group plan by completing and filing a waiver form at Fall Semester registration. Forms for this purpose are available in the Student Accounts office.

Students who present satisfactory evidence of comparable health insurance coverage to the University, will be waived from coverage. Satisfactory evidence of comparable coverage cannot be accepted after 31 days following the beginning of the term or semester that coverage is to begin.

GRADUATE STUDENTS are also eligible. Graduate student coverage is on a voluntary basis and billings will not be sent. Premium must be paid to USI NW within 31 days from the beginning of each semester. See center of brochure for Enrollment form.

SUMMER COVERAGE is available for all students and their dependents who were insured on the plan Spring Semester 2006. **Enrollment in summer coverage is recommended.** Summer coverage is not available to those who were not insured Spring Semester 2006, including dependents.

ENROLLMENT FORM FOR SUMMER COVERAGE IS LOCATED IN THE CENTER OF THIS BOOKLET.

DATES OF COVERAGE:

Fall Semester	8/29/05 – 1/15/06
Spring Semester	1/16/06 – 5/15/06
Summer Coverage	5/16/06 – 8/28/06

PREMIUMS WILL NOT BE PRO-RATED. Refund of premium is allowed only upon entry into the Armed Forces.

DEPENDENT COVERAGE

Eligible students who are enrolled in the student medical plan may also insure their Dependents.

Eligible Dependents are the spouse and unmarried children under 19 years of age, or 25 years of age, if a full-time student at an accredited institution of higher learning and are fully dependent on the insured student.

“Newborn Child” means: 1) a newly born child of the Insured from the moment of birth provided that the Insured is Insured under this Policy; 2) a child to whom a decree of adoption by the Insured has been entered within thirty-one days after the date of the child's birth and the Insured has temporary custody of the child provided the person adopting the child is Insured under this Policy on the date the child is placed with the Insured; and 3) a child adopted by the Insured 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 this Policy on the date the adoption becomes effective.

Dependent eligibility expires concurrently with that of the insured student.

To enroll your dependents for coverage on the University of Portland student medical plan, please use the enrollment form in center of this brochure, complete and send it with a check to USI NW, 700 NE Multnomah St. Suite 1300, Portland OR 97232.

PRE-EXISTING CONDITION LIMITATION

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 Qualifying Prior Coverage if the coverage was in force within 63 days prior to the effective date of this coverage. Coverage for a student is considered continuous from one school year to the next while we have coverage in force with the school. The student is permitted to have a one term or a 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 entity that provides or arranges medical, hospital and surgical coverage which does not supplement other private or governmental plans. This includes continuous 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.

PREFERRED PROVIDER INFORMATION

Please read the following information so you will know from whom or what group of providers health care may be obtained. "**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 the Community Care Network (CCN) Preferred Provider Network. This enhancement to your program *does not* require you to use a CCN Preferred Provider. You may receive care from any licensed provider (benefit eligibility is subject to the plan design and the exclusion and limitations as specified in the policy), but if you incur an expense using a CCN Preferred Provider, you will lower your out-of-pocket expense. **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 CCN Website at www.ccnusa.com, calling 1-800-226-5116 or 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 or the Provider's charge for the service, whichever is less.



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 CCN Website at www.ccnusa.com, calling 1-800-226-5116 and by asking the provider when you make an appointment for services.

PRESCRIPTIONS

Prescriptions may be purchased at any pharmacy.

You must purchase your prescription and then send the itemized-prescription receipt to PIA with a claim form.

Your claim will be processed and any reimbursement will be mailed directly to you.

If you do not have a claim form you may obtain one at the Student Health Service, by calling USI NW at 1-800-251-4246 or (503) 295-6357; or at www.piaclaims.com.

DEFINITIONS

1. **Coinsurance** means the percentage amount of covered expense 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. Caesarean 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. Lives within the United States;
 - b. Chiefly relies on you for support and maintenance; 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

DEFINITIONS, CONT'D.

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** includes a physician assistant licensed under ORD 655.515(4) when acting within the scope of 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.
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.

Hospital includes a hospital owned or operated by the State of Oregon or any state approved community mental health and developmental disabilities program.
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. 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 reasonably expect that failure to receive immediate medical attention would place the health of

DEFINITIONS, CONT'D.

- 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.
 15. **Negative X-ray** means an X-ray that shows the absence of a fracture, pathology, or disease
 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.
 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 the University of Portland.
 20. **Positive X-Ray** means an X-ray that shows the presence of a fracture, pathology, or disease.
 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 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
 - i. 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 80th percentile.

SCHEDULE OF BENEFITS

The Policy provides for the Usual, Customary and Reasonable Charges (UCR) incurred by an Insured Person for loss due to a medically necessary covered Injury or Sickness. If you receive care from a Preferred Provider, any Covered Medical expenses 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. Preferred Providers are part of The Community Care Network (CCN) Preferred Provider Network at www.ccnusa.com or 1-800-226-5116 (24 hours a day.)

Lifetime Maximum\$15,000* (Up to \$1,500 of used benefits automatically renews each year.)
 Policy Year Deductible\$25 Deductible per policy year (School year) for each covered person
 After your deductible has been met.....The first \$300 of eligible expenses are paid at 100%*

***Limited benefits for Inpatient and Outpatient treatment of Mental or Nervous Disorders.**

THEREAFTER THE PLAN PAYS:

INPATIENT EXPENSES

	<u>In-Network</u>	<u>Out-of-Network</u>
Hospital Expenses, daily semi-private room rate; general nursing care 90% of Preferred Allowance 80% of UCR Charges <i>provided by Hospital; Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests, x-ray examinations, anesthesia, drugs (excluding take-home drugs) or medicines, therapeutic services, and supplies</i>		
Intensive Care/Hospital Expenses 90% of Preferred Allowance 80% of UCR Charges		
Mental and Nervous Disorders. 90% of Preferred Allowance 80% of UCR Charges		
Physiotherapy <i>benefits are limited to one visit per day, 10 days maximum.</i> 90% of Preferred Allowance 80% of UCR Charges		

INPATIENT / OUTPATIENT EXPENSES

	<u>In-Network</u>	<u>Out-of-Network</u>
Surgeon / Asst. Surgeon Fees 90% of Preferred Allowance 80% of UCR Charges <i>No more than one surgical procedure will be covered when multiple procedures are performed through the same incision or in immediate succession.</i>		
Anesthetist 90% of Preferred Allowance 80% of UCR Charges		
Registered Nurse's Services, private duty nursing care 90% of Preferred Allowance 80% of UCR Charges		
Doctor's Visits, benefits are limited to one visit per day. Benefits for 90% of Preferred Allowance 80% of UCR Charges <i>Doctor's visits do not apply when related to surgery</i>		
Consultant Physician Fees, when requested and approved by the attending Physician 90% of Preferred Allowance 80% of UCR Charges		
Pre-admission Testing 90% of Preferred Allowance 80% of UCR Charges		
Chiropractic Care 90% of Preferred Allowance 80% of UCR Charges		
Diagnostic X-Ray 90% of Preferred Allowance 80% of UCR Charges		
Laboratory Services. 90% of Preferred Allowance 80% of UCR Charges		
Chemical Dependency, alcohol and drug addiction 90% of Preferred Allowance 80% of UCR Charges <i>Inpatient or Outpatient treatment \$4,500 in any 24 month period</i>		
Radiation Therapy and Chemotherapy. 90% of Preferred Allowance 80% of UCR Charges		

OUTPATIENT EXPENSES

	<u>In-Network</u>	<u>Out-of-Network</u>
Day Surgery Miscellaneous, related to scheduled surgery performed in a 90% of Preferred Allowance 80% of UCR Charges <i>Hospital; including the cost of the operating room; laboratory tests and X-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.</i>		
Emergency Room Expenses, attending doctor's charges, x-rays, laboratory 90% of Preferred Allowance 80% of UCR Charges <i>procedures, injections, use of the emergency room and supplies</i>		
Mental and Nervous Disorders, \$1,000.00 maximum (Per Policy Year) 90% of Preferred Allowance 80% of UCR Charges		
Injections, when administered in the Doctor's office and charged on the 90% of Preferred Allowance 80% of UCR Charges <i>Doctor's statement</i>		
Physiotherapy <i>benefits are limited to one visit per day, 10 days maximum.</i> 90% of Preferred Allowance 80% of UCR Charges		
Prescription Drugs <i>Based on a 30 day supply.</i> 80% (Refer to Page 3)		

OTHER

	<u>In-Network</u>	<u>Out-of-Network</u>
Ambulance Service 80% of UCR Charges		
Dental Treatment, made necessary by Injury to Sound, Natural Teeth 90% of Preferred Allowance 80% of UCR Charges		
Hospice Care. 90% of Preferred Allowance 80% of UCR Charges		
Home Health. 90% of Preferred Allowance 80% of UCR Charges		
Durable Medical Equipment 90% of Preferred Allowance 80% of UCR Charges		
External Prosthetic Appliances. 90% of Preferred Allowance 80% of UCR Charges		
Maternity <i>Same as any other sickness.</i> 90% of Preferred Allowance 80% of UCR Charges		

"UCR" = Usual, Customary and Reasonable Charges.

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 for a period of six months, unless Qualifying Prior 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 list 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.
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; 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; infertility diagnosis or treatment including in-vitro fertilization, artificial insemination and any other form of assisted conception; sterilization or sterilization reversal, vasectomy or vasectomy reversal; family planning, expenses incurred for birth control drugs, supplies or devices including oral contraceptives used for birth control; hair growth,

EXCLUSIONS AND LIMITATIONS, CONT'D.

- 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.
 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.

ADDITIONAL BENEFITS

The following additional benefits are covered subject to policy benefits and limitations:

1. Mammograms: 1 between the ages of 35-40; annually age 40 and over or more frequently if designated as high risk.
2. Pap, Pelvic & Breast exams: annually for women age 18 to 64 and at any time upon referral of a health care provider.
3. Non-prescription elemental enteral formula for home use if:
 - a. formula is medically necessary for treatment of severe intestinal malabsorption
 - b. physician wrote an order for the formula
 - c. formula comprises the sole source (essential) of nutrition.
4. Diabetes Self-Management and Education as specified in the policy.

MEDICAL EVACUATION BENEFIT

THIS BENEFIT WILL NOT BE PAYABLE IN THE EVENT OF THE COVERED PERSON'S DEATH

Subject to prior approval from the Company, the policy will pay up to a maximum benefit of \$10,000 of the eligible expenses incurred while the Policy is in force:

1. following a covered Injury or Sickness;;
2. for emergency evacuation required by the Covered Person;
3. while he is outside his home country;
4. if the Covered Person's doctor determines that adequate medical treatment is not locally available and written certification is provided;
5. does not occur prior to the benefits approval;
6. up to the Maximum Benefit Amount of \$10,000

Benefits are payable for:

1. Usual, Customary and Reasonable charges for medical services required for evaluation to the nearest adequate medical facility;
2. Usual, Customary and Reasonable charges for escort services required by the Covered Person, if his is disabled and an escort is recommended in writing by his Doctor; and
3. ambulance services to the nearest airport and air ambulance upon departure; and
4. special air transportation costs to return the Covered Person to his home country, if his Doctor recommends in writing that his condition requires a stretcher, oxygen or other special medical arrangements; and
5. expenses above the cost of a return airfare ticket held by the Covered Person or in the absence of a ticket, the cost of an economy airfare ticket.

If services provided are covered under any Worker's Compensation, then the Covered Person shall assign to us his rights to those benefits, to the extent they are provided.

REPATRIATION BENEFIT

The policy will cover, up to a maximum benefit of \$7,500 of eligible expenses which are incurred while this Policy is in force, with prior approval from the Company;

1. for returning a Covered Person to his place of residence in his home country;
2. if he dies as a result of a covered Injury or Sickness;
3. while outside his home country;
4. while he is covered under the Policy;
5. up to the Maximum Benefit Amount of \$7,500 of eligible expenses; and
6. with prior approval from the Company.

Expenses that are covered include, but are not limited to:

1. The cost of embalming; and
2. Shipping Container and transportation of the body.

This benefit does not include transportation expenses for any person accompanying the body.

HOW TO FILE A CLAIM

In the event of Injury or Sickness, the student should:
IF A MEDICAL EMERGENCY, CALL 911 OR REPORT TO
THE NEAREST EMERGENCY ROOM

- 1) Report to the Student Health Center for treatment, or when not in school, to a Physician or Hospital.
- 2) Obtain a claim form from the Student Health Center by calling USI NW at 1-800-251-4246 or by printing from 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 fifteen months from the date when the proof was originally required. A completed Claim Form must accompany each Injury or Sickness.

You have the right to request an independent medical review if health care services have been improperly denied, modified, or delayed based on medical necessity.

- 4) SEND CLAIM FORMS ALONG WITH ITEMIZED HOSPITAL AND MEDICAL BILLS TO:

Personal Insurance Administrators, Inc.

PO Box 6040

Agoura Hills, CA 91376-6040

1-800-468-4343

www.piaclaims.com

Below is your permanent ID Card.

Please cut out and carry with you at all times.

THIS IS YOUR PERMANENT ID CARD
For information on CCN preferred providers, access www.ccnusa.com or call 1-800-226-5116.
NOTE: Benefits are subject to payment of appropriate premium and verification of eligibility.
1-800-468-4343
Agoura Hills, CA 91376-6040
PO Box 6040
Personal Insurance Administrators, Inc.
Submit All Claims or Inquiries to:
CCN Administered By: Personal Insurance Administrators, Inc.
Insured _____
Student of UNIVERSITY OF PORTLAND 2005-2006 Student Health Insurance Plan
Underwritten By: FAIRMONT PREMIER INSURANCE COMPANY Policy No. 18021
Both the effective and termination dates of coverage are subject to verification by the Company.(Address on reverse side)

Underwritten and Insured by:
FAIRMONT PREMIER INSURANCE COMPANY
TINTON FALLS, NJ

***For Benefits, Eligibility or Claim
Inquiries Contact:***

PERSONAL INSURANCE ADMINISTRATORS,
INC.

PO Box 6040
Agoura Hills, CA 91376-6040

1-800-468-4343

**You may print claim forms, ID cards and brochures
from: www.piaclaims.com**

Agents:
USI NW
Rico Bocala
Patricia Wylie
Brysis Boyd
Portland, Oregon
1-800-251-4246

A Partner Company  Insurance Services Corp.

Important Notice:

This brochure describes the important features of Student Health Policy No. 18021. Please be sure to retain this brochure, as it outlines the provisions of the coverage which is on file at the Office of the Dean of Students. No individual policies or certificates are issued. Any discrepancy between this brochure and the Policy, the Policy will prevail.

Revised 6/05

ENROLLMENT FORM

2005-2006 UNIVERSITY OF PORTLAND ENROLLMENT FORM STUDENT ACCIDENT & HEALTH INSURANCE FOR GRADUATE STUDENTS, DEPENDENT AND/OR SUMMER COVERAGE ONLY

1. _____ Male
 (Print) Primary Applicant's Last Name First Name MI Female
2. _____
 (Mailing Address) Address City State Zip
3. ____/____/____ (____)_____
 Date of Birth Social Security Number Telephone Number

4. **Indicate Coverage Selected: (Please circle)**

	Fall 8/29/05 – 1/15/06	Spring 1/16/06 – 5/15/06	Summer 5/16/06 – 8/28/06
Undergraduate Student Only*	N/A*	N/A*	\$300.00
Graduate Student Only	\$341.00	\$341.00	\$421.00
For one dependent, an additional	\$370.00	\$370.00	\$336.00
For two or more dependents, an additional	\$798.00	\$798.00	\$698.00

*Undergraduate Student only premium for fall and/or spring semester is charged to your student account at UP. This form is only for graduate students purchasing coverage, students purchasing dependent coverage or students purchasing summer coverage.

TOTAL AMOUNT SUBMITTED: \$ _____

PAYMENT METHOD: CHECK OR MONEY ORDER

MAKE PAYABLE TO: USI NW

SEND TO: 700 NE MULTNOMAH SUITE 1300, PORTLAND OR 97232

5. **Dependent Information** (Please Print):
- Spouse: _____ Male
 Last Name First Name MI Female Date of Birth ____/____/____
- Child: _____ Male
 Last Name First Name MI Female Date of Birth ____/____/____
- Child: _____ Male
 Last Name First Name MI Female Date of Birth ____/____/____

6. By signing below, I certify that I and the individuals named herein are eligible for the insurance.

 Signature Printed Name Date