

**2005 - 2006
STUDENT
HEALTH
INSURANCE
PLAN**



WESTERN STATES
CHIROPRACTIC
COLLEGE
Portland, Oregon

Underwritten by:
Fairmont Premier Insurance Company
Tinton Falls, NJ
Policy #18028

CAWSCC-05

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ELIGIBILITY

The insurance plan described in this brochure provides medical Insurance for Sickness or Injury. Coverage is available for school terms, vacation terms and for a maximum of one term following graduation. The Policy year runs from September 29, 2005 to September 27, 2006.

ALL ENROLLED, TUITION-PAYING STUDENTS are automatically covered under Plan Two of this insurance program. The premium is included in the fee schedule each term. Any student who wishes to change to Plan One must do so within the first 30 days of coverage. Any student with existing comparable health insurance coverage may be exempted from participation in the college's group plan by completing and filing a waiver form each policy year. Forms for this purpose are available in the Student Services office.

Please note: You will not be able to switch plans after your initial enrollment. Once you have enrolled in a plan for the 2005-2006 school year, you cannot change plans for the balance of the school year.

The plan is also available to dependents. Students must be insured by the Policy in order to cover their dependents under the Policy. Dependents must be enrolled in the same plan as the covered student. "Dependents" are defined as an Insured Student's spouse, domestic partner, if living with the student, and the student's unmarried children to 19 years of age. Dependents also include the Insured Student's unmarried dependent children who are 19 to 25 years old and attending school full-time; and children 19 or more years of age, and primarily supported by the Insured Student and incapable of self-sustaining employment by reason of mental or physical handicap. In addition to the Insured Student's natural born children, the word children shall also include any legally adopted child, stepchild or foster child who lives with the student. Dependents may only be insured for the terms of coverage for which the Insured Student is covered. A newborn child or a child placed with you for adoption shall be covered for 31 days from birth or date of placement. During these 31 days we must receive written notice of the birth or placement and receive the required premium for coverage to continue.

Your insurance will end for you and your Dependents on the earliest of the date you are no longer in an eligible class, you become full time active duty in any armed forces, you reach the end of the period for which premium was paid, the policy is terminated, or the date the subscriber ceases to be a participant under the Policy.

COVERAGE

The plan protects the Insured Person 24 hours a day during the period for which premium has been paid, WHETHER ON CAMPUS, OR AT HOME, OR WHILE TRAVELING. Insurance continues in force during the period for which premium has been paid whether or not the student remains at WSCC. If your college has granted you a leave of absence, check with the Office of Student Services about your insurance coverage. Coverage for students and dependents is identical. This insurance plan provides a choice of two plan designs. The lifetime maximum coverage available to you will never be greater than the lifetime maximum in effect at the time that any Sickness or Injury becomes eligible for benefits under this insurance plan.

PREFERRED PROVIDER INFORMATION

The Western States Chiropractic College student health insurance plan utilizes the preferred providers of the CCN Network. 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 exclusions and limitations as specified in the policy), but if you incur any expenses using a CCN 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.

“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.

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 or calling 1-800-226-5116, or by asking the provider when you make an appointment for services.

COVERED EXPENSES

Covered Expenses are the Usual, Reasonable and Customary charges for care and services for treatment of an Injury or Sickness for the following:

1. Those in-patient charges made by a Hospital for medical care and services up to the daily cost of a semi-private room and in-patient miscellaneous expenses;
2. Those made by a licensed Doctor, as defined for a Medical Emergency (including critical and emergency extended care visits);
3. Those made by a professional ambulance service for transportation of an individual from the place where an Sickness or Injury has its inception to a covered Hospital;
4. Prescription drugs;
5. Mammograms: A screening mammogram between the ages of 35 and 40; annual mammogram for breast cancer screening or diagnostic purposes age 40 and over or more frequently if designated at high risk;
6. Annual breast, pelvic and pap smear examination for women age 18 to 64 and at anytime upon referral of a health care provider;
7. Diabetes self management and education;
8. Non-prescription elemental enteral formulas for home treatment of severe intestinal malabsorption if the formula comprises the sole source (essential of nutrition). A physician must issue a written order.

MATERNITY

The mother's expenses are covered the same as a Sickness and are subject to the same limitations.

Routine in-hospital newborn care and nursery charges will be considered Covered Expenses.

PRESCRIPTION DRUG BENEFIT

After a \$10 Co-payment for generic or 50% for brand name drug per prescription (Plan 1) or after a Co-payment of \$10 for generic or \$25 for a brand name drug per prescription (Plan 2), the cost of prescription drugs is payable in full, up to the maximum benefit.

Prescriptions must be filled at an EBRx participating pharmacy. You may check the list of participating pharmacies at www.ebrx.com.

The following drugs are excluded from coverage under this benefit: birth control pills, 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.

2005 - 2006 PREMIUMS

PLAN ONE				
TERM	FALL 9/29/05 – 1/5/06	WINTER 1/6/06 – 4/9/06	SPRING 4/10/06 – 7/16/06	SUMMER 7/17/06 – 9/27/06
Student	\$254.00	\$254.00	\$254.00	\$254.00
Spouse	\$616.00	\$616.00	\$616.00	\$616.00
Per Child	\$318.00	\$318.00	\$318.00	\$318.00

PLAN TWO				
TERM	FALL 9/29/05 – 1/5/06	WINTER 1/6/06 – 4/9/06	SPRING 4/10/06 – 7/16/06	SUMMER 7/17/06 – 9/27/06
Student	\$353.00	\$353.00	\$353.00	\$353.00
Spouse	\$786.00	\$786.00	\$786.00	\$786.00
Per Child	\$406.00	\$406.00	\$406.00	\$406.00

Premiums will not be pro-rated.

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. In order to obtain a Certificate of Creditable Coverage; please contact USI at 1-800-251-4246.

SCHEDULE OF BENEFITS –PLAN ONE

Lifetime Maximum\$250,000

Policy Year Deductible\$1,000 per person

AFTER YOUR DEDUCTIBLE HAS BEEN MET, COVERED EXPENSES ARE PAID ON THE FOLLOWING BASIS:

INPATIENT EXPENSES	In-Network	Out-of-Network
Room & Board Expenses , including general nursing care, semi private room rate.	100% of Preferred Allowance 30 day policy year maximum benefit	80% of UCR
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.	100% of Preferred Allowance \$2000 policy year maximum benefit	80% of UCR
Intensive Care Expenses	Covered under Room and Board Expense	
Physiotherapy , when prescribed by a Doctor	Covered under Hospital Miscellaneous Expenses Maximum 1 visit per day	
Surgery , No more than one surgical procedure will be covered when multiple procedures are performed through the same incision. Doctor's fees for surgical procedure will be paid in accordance with Ingenix at the 80th percentile.	100% of Preferred Allowance \$3000 policy year maximum benefit	80% of UCR
Mental Nervous Disorders , covered as any other sickness. This includes the treatment of mental or nervous disorders, alcoholism and drug addiction.	100% of Preferred Allowance \$5000 policy year maximum benefit	80% of UCR
INPATIENT / OUTPATIENT EXPENSES	In-Network	Out-of-Network
Anesthetist , in conjunction with surgery	100% of Preferred Allowance Max. benefit - 25% of surgery fee paid	80% of UCR
Doctor's Visits , Benefit limited to one visit per day when a surgery benefit is not paid.	100% of Preferred Allowance \$50 per visit, 30 day policy year maximum	80% of UCR
Consultant Doctor's Fees , When requested by the attending Doctor	100% of Preferred Allowance \$70 maximum per visit, 5 visit policy year maximum	80% of UCR
Emergency Room Expenses , attending doctor's charges, x-rays, laboratory procedures, injections, use of the emergency room and supplies. <i>*Waived if admitted</i>	100% of Preferred Allowance, after \$50 copay * \$200 policy year maximum benefit	80% of UCR, after separate \$50 deductible *
OUTPATIENT EXPENSES	In-Network	Out-of-Network
Surgery , no more than one surgical procedure will be covered when multiple procedures are performed through the same incision. Doctor's fees for surgical procedure will be paid in accordance with Ingenix at the 80th percentile.	100% of Preferred Allowance \$2000 policy year maximum	80% of UCR
Day Surgery Miscellaneous , when surgery is performed in a hospital emergency room, trauma center, Doctor's office, outpatient surgical center or clinic, for services and supplies such as; 1) operating room; 2) laboratory test; 3) x-ray examinations; 4) anesthesia; 5) drugs or medicines; and 6) therapeutic services (excluding physiotherapy); etc.	100% of Preferred Allowance \$1000 policy year maximum	80% of UCR
Physiotherapy	100% of Preferred Allowance \$50 maximum per visit / \$500 policy year maximum	80% of UCR
Outpatient Miscellaneous Benefit , 1.) Diagnostic x-ray services; 2.) laboratory procedures; and 3.) chemotherapy when prescribed by attending Doctor.	100% of Preferred Allowance \$250 policy year maximum	80% of UCR
Mental or Nervous Disorders , includes the treatment of mental or nervous disorders, alcoholism and drug addiction.	50% of Preferred Allowance \$500 policy year maximum benefit	50% of UCR
Prescription Drugs , Must be purchased at an EBRx Participating Network Pharmacy (Not subject to deductible) see page 4 for details.	\$10 copay for generic or 50% copay for brand name \$1000 policy year maximum benefit	
OTHER EXPENSES	In-Network	Out-of-Network
Ambulance Services , for transportation to or from a hospital	80% of UCR Maximum \$250 per trip	
Well Child / Baby Care , (not subject to deductible)	100% of Preferred Allowance After a \$15 copay Maximum \$75 per visit	80% of UCR after separate \$15 deductible
WESTERN STATES CHIROPRACTIC COLLEGE OUTPATIENT CLINIC SERVICES		
Office Visit , chiropractic manipulations only (not subject to deductible)	\$15 copay per visit Maximum 2 visits per injury or sickness, \$35 benefit maximum per visit	
Lab or X-ray , not subject to deductible.	\$15 copay per visit \$50 maximum benefit, per injury or sickness.	

SCHEDULE OF BENEFITS – PLAN TWO

Lifetime Maximum\$1,000,000

Policy Year Deductible\$250 per person

AFTER YOUR DEDUCTIBLE HAS BEEN MET, COVERED EXPENSES ARE PAID ON THE FOLLOWING BASIS:

INPATIENT EXPENSES	In-Network	Out-of-Network
Room & Board Expenses , including general nursing care, semi private room rate.	100% of Preferred Allowance	80% of UCR
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.	100% of Preferred Allowance	80% of UCR
Intensive Care Expenses	100% of Preferred Allowance	80% of UCR
Physiotherapy , when prescribed by a Doctor.	<i>Covered under Hospital Miscellaneous Expenses Maximum 1 visit per day</i>	
Mental Nervous Disorders , covered as any other sickness. This includes the treatment of mental or nervous disorders, alcoholism and drug addiction.	100% of Preferred Allowance	80% of UCR 60 day policy year maximum
INPATIENT / OUTPATIENT EXPENSES	In-Network	Out-of-Network
Surgery , No more than one surgical procedure will be covered when multiple procedures are performed through the same incision. Physician fees for surgical procedure will be paid in accordance with Ingenix at the 80th percentile.	100% of Preferred Allowance	80% of UCR
Anesthetist , in conjunction with surgery.	100% of Preferred Allowance Maximum benefit is 30% of surgery fee paid	80% of UCR
Doctor's Visits , Benefit limited to one visit per day when a surgery benefit is not paid	100% of Preferred Allowance after a \$15 copay	100% of UCR subject to \$15 deductible per visit (not subject to deductible)
Consultant Doctor's Fees : When requested by the attending Doctor	100% of Preferred Allowance	80% of UCR
Emergency Room Expenses , attending doctor's charges, x-rays, laboratory procedures, injections, use of the emergency room and supplies. <i>*Waived if admitted)</i>	100% of Preferred Allowance, after \$50 copay for sickness*	80% of UCR, after separate \$50 deductible for sickness* \$1000 policy year maximum benefit
OUTPATIENT EXPENSES	In-Network	Out-of-Network
Day Surgery Miscellaneous , when surgery is performed in a hospital emergency room, trauma center, Doctor's office, outpatient surgical center or clinic, for services and supplies such as; 1) operating room; 2) laboratory test; 3) x-ray examinations; 4) anesthesia; 5) drugs or medicines; and 6) therapeutic services (excluding physiotherapy); etc.	100% of Preferred Allowance	80% of UCR
Physiotherapy	100% of Preferred Allowance	80% of UCR \$50 maximum per visit
Outpatient Miscellaneous Benefit , 1) Diagnostic x-ray services; 2) laboratory procedures; 3) chemotherapy when prescribed by attending Doctor.	100% of Preferred Allowance after a \$15 copay	80% of UCR after separate \$15 deductible subject to deductible
Mental or Nervous Disorders , includes the treatment of mental or nervous disorders, alcoholism and drug addiction.	50% of Preferred Allowance	50% of UCR \$5000 policy year maximum benefit
Prescription Drugs , Must be purchased at an EBRx Participating Network Pharmacy (Not subject to deductible) see page 4 for details.	\$10 copay for generic or \$25 copay for brand name	
OTHER EXPENSES	In-Network	Out-of-Network
Ambulance Services , for transportation to or from a hospital	80% of UCR \$250 maximum per trip	
Well Child/Baby Care (Not subject to deductible)	100% of Preferred Allowance After a \$15 copay	80% of UCR After separate \$15 deductible
WESTERN STATES CHIROPRACTIC COLLEGE OUTPATIENT CLINIC SERVICES		
Office Visit , chiropractic manipulations only (not subject to deductible)	\$15 copay per visit Maximum 2 visits per condition, \$35 benefit maximum per visit	
Lab or X-ray , (not subject to deductible)	\$15 copay per visit \$50 maximum benefit, per injury or sickness.	

PRE-EXISTING CONDITIONS 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. 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 semester break without restarting the pre-existing condition period. "Qualifying Prior Coverage" means an 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.
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

DEFINITIONS, CONT'D.

- 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
 - 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 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.
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 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;

DEFINITIONS, CONT'D.

- The aged, drug addicts or alcoholics; or
 - Rehabilitation.
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 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,

DEFINITIONS, CONT'D.

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 Western States Chiropractic College.
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. 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.
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.
23. **Spouse** means your lawful spouse.
24. **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.
25. **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 80th percentile.

EXCLUSIONS

The Policy does not cover nor provide benefits for:

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 the Covered Person has Qualifying Prior Coverage.
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 bungli-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, 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.
15. Elective surgery and elective treatment, including but not limited to; acupuncture; birth control, including 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; infertility diagnosis or treatment; family planning; expenses incurred in connection with sterilization or sterilization reversal, vasectomy or vasectomy reversal; hair growth, replacement or removal, alopecia; impotence, organic or otherwise; learning disabilities, except for

EXCLUSIONS, CONT'D.

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; speech exams unless medically necessary; 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, employer's 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.

EXTENSION OF BENEFITS

EXTENSION OF BENEFITS AFTER TERMINATION - The coverage provided under this policy ceases on the end of the term of coverage. However, if a covered person is Hospital Confined on the end of the term of coverage from a covered injury or sickness for which benefits were paid before such date, covered expenses for such injury or sickness will continue to be paid as long as the condition continues but not to exceed 30 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the end of the term of coverage will never exceed the maximum benefit amount under the policy.

PRIMARY MEDICAL EXPENSE

If an Insured Person incurs Covered Expenses for any of the services on the Schedule of Benefits, we will pay the applicable benefit, subject to the Deductible Amount and Benefit Percentage (if any).

Covered Expenses must be incurred while the Insured is covered under this Policy.

The total of all medical benefits payable under the Policy is shown on the Schedule of Benefits and is subject to the specific maximums shown on the Schedule of Benefits.

SUBROGATION

If we have paid benefits to 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 benefits paid or to any settlement or judgment which results from the exercise of these rights. The Covered Person agrees to sign papers and 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.

REFUNDS

Refunds of premiums to Covered Persons and Dependents are allowed only upon entry into the armed forces, provided there have been no claims filed during the Policy year and provided that request is made in writing to the Company. No covered Person shall be entitled to a refund of premium because of withdrawal from the College.

Please keep this brochure as a general summary of the Insurance. The Policy on file at the College contains all of the provisions, exclusions and qualifications of your Insurance benefits, some of which may not be included in this brochure. If any discrepancy exists between brochure and Policy, the Policy will govern and control the payment of benefits.

ACCIDENTAL DEATH AND DISMEMBERMENT

If, within one year from the date of an accident covered by the Policy, Injury from such accident, results in Loss listed below, we will pay the benefit set opposite such Loss, if the Insured Person sustains more than one such Loss as the result of one accident, we will pay only one amount, the largest to which he is entitled. This amount will not exceed the Principal Sum which applies for the Insured Person.

Accidental Death	\$2,000
Accidental Dismemberment:	
Both Hands, Feet or eyes.	\$2,000
One Hand and One Foot	\$2,000
Hand or One Foot and One Eye	\$2,000
Either Hand or Foot	\$1,000
Sight of One Eye	\$1,000
Loss of Thumb and Index Finger of the Same Hand	\$500

Loss of a hand or foot means complete Severance through or above the 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. Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

“Severance” means the complete separation and dismemberment of the part from the body.

STUDENT TRAVEL ASSISTANCE PLAN

In addition to this health policy, you have a student travel assistance plan, 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 student travel 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. The student travel assistance plan is provided by MEDEX Assistance Corporation.

Upon enrollment to the Western States Chiropractic College Student Health Plan, you will be sent a packet from USI which will include a MEDEX brochure. A toll free or collect call immediately links you to MEDEX's high trained, multilingual assistance coordinations, 24 hours a day, 365 days a year.

1-800-537-2029 or 410-453-6330
www.medexassist.com
Group # 7274

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) Obtain a claim form from Student Services, by calling USI at 1-800-251-4246 or 503-295-6357 or printing from www.piaclaims.com.
- 2) 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.
- 3) Send claim forms along with itemized hospital and medical bills to:



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

1-800-468-4343

www.piaclaims.com

The Company shall be fully and completely subrogated, unless otherwise prohibited by law, to the rights of the Covered Person's 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 this Policy.

BELOW IS YOUR PERMANENT ID CARD.

CUT OUT AND CARRY WITH YOU AS PROOF OF COVERAGE.

group number as 7274.
1-410-453-6330 collect from outside the USA and identify your
To utilize these travel services please call 1-800-537-2029 or
through MEDEX Assistance Corporation.
Your plan contains the student travel assistance program offered
OTHER SERVICES
Customer Service: 1-888-274-6214
Pharmacy Helpline: 1-800-406-0015
MediCarrier #: 95
EBRX Bin#: 610560
Group No. PIA WC05
FOR PHARMACY USE ONLY:
EBRX, Inc.
*Present this card to participating EBRx
Pharmacy when filling a prescription.*

WESTERN STATES CHIROPRACTIC COLLEGE
STUDENT HEALTH INSURANCE PLAN
INSURED BY: FAIRMONT PREMIER INSURANCE COMPANY
Policy No. 18028

INSURED STUDENT _____

SEND MEDICAL CLAIMS TO:
PERSONAL INSURANCE ADMINISTRATORS, INC.
P.O. Box 6040
AGOURA HILLS, CA 91376-6040
1-800-468-4343

CCN

NOTE: Benefits are subject to payment of appropriate premium
and verification of eligibility.

Preferred Providers are part of the CCN Network,
1-800-226-5116 or www.ccnusa.com

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

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. 18028. 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 6/05