THE MASTER'S
UNIVERSITY

Student Health Insurance Plan

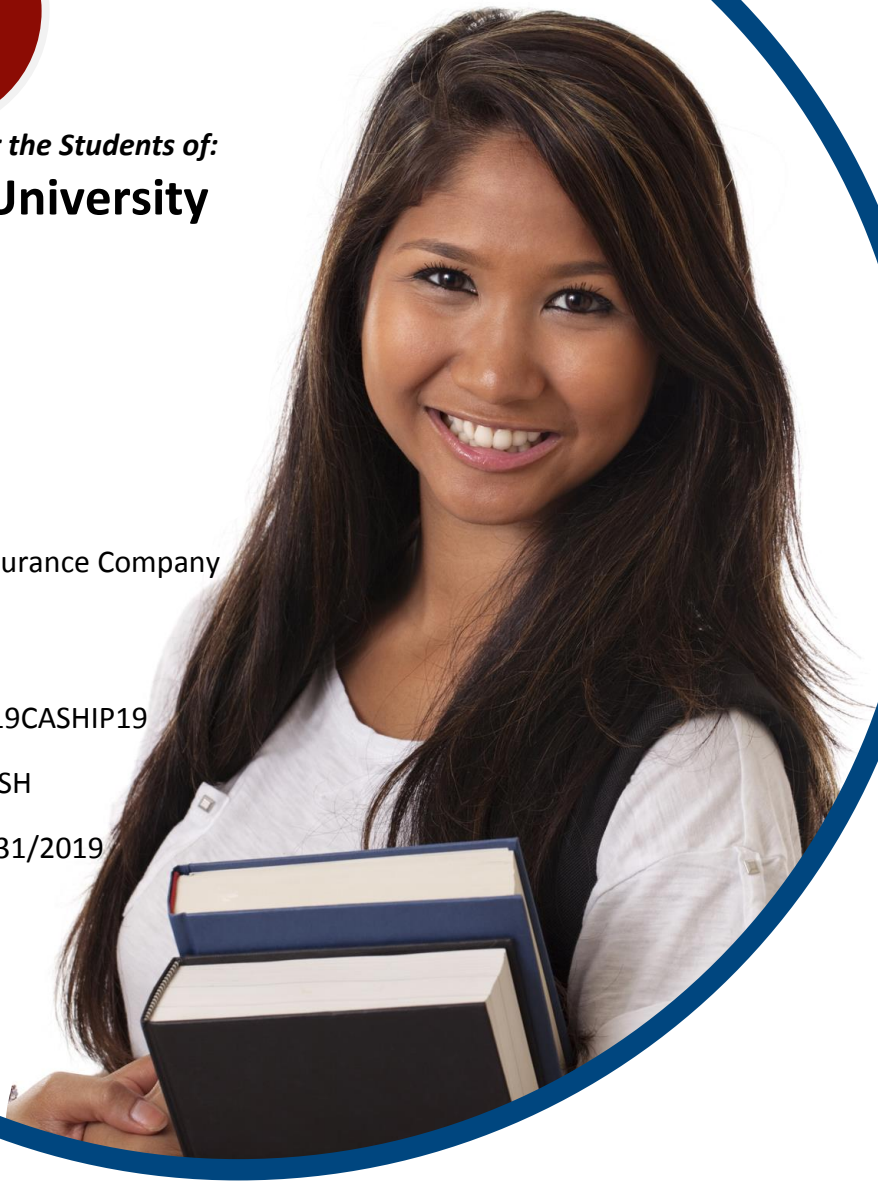
Plan Year 18/19

Designed Exclusively for the Students of:

The Master's University and Seminary

Santa Clarita, CA
("the Policyholder")

2018 - 2019



Underwritten by:
Commercial Casualty Insurance Company
Fort Wayne, IN
("the Company")

Policy Number: CCIC1819CASHIP19

Group Number: ST1021SH

Effective: 8/1/2018 - 7/31/2019

Administered by:
Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA

CHP Student HEALTH

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Where to Find Help

For Questions About:	Please Contact:
Insurance Benefits **Enrollment** **Waiver**	**Servicing Agent:** JCB Insurance Solutions 2277 Fair Oaks Blvd, Suite 415 Sacramento, CA 95825 (661) 320-3036 StudentServices@jcbins.com
Claims Processing **ID Cards** **Preferred Provider Listings** **ID card Requests**	**Consolidated Health Plans** **2077 Roosevelt Avenue** **Springfield, Massachusetts 01104** **(877) 657-5030** www.chpstudenthealth.com
Preferred PPO Provider Listings Cigna.	**Consolidated Health Plans** www.chpstudenthealth.com or **Cigna Open Access Plus (OAP)** **www.cigna.com**
Prescription Drug Providers	BeRx PBM www.berxplan.com

Am I Eligible?

You are eligible for Coverage under the Certificate. Coverage includes Dependent coverage.

Students must attend classes for the first 31 days beginning with the first day for which coverage is effective. Any student withdrawing from the College during the first 31 days after the Effective Date of coverage shall not be covered under the insurance plan. A full refund of premium will be made, minus the cost of any claim benefits paid by the Certificate. Students who graduate or withdraw from the College after first 31 days, whether involuntarily or voluntarily, will remain covered under the Certificate for the term purchased and no refund will be allowed.

Students withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school. Students will remain covered under the Certificate for the term purchased and no refund will be allowed.

All International Students are required to have a J-1, F-1 or M-1 Visa and dependents have a J-2, F-2 or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Certificate eligibility requirements have been met. If We discover that the Certificate eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid.

Eligibility requirements must be met each time Premium is paid to renew Coverage.

Who is Eligible

All registered full-time Undergraduate, Domestic, and International students taking 6 or more credits are required to have health insurance coverage, either through this Student Health Insurance Plan or through another individual or family plan. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition fees unless proof of comparable coverage is provided by completing the waiver.

Who is not Eligible

The following students are not eligible to enroll in the insurance plan:

- students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses;
- students taking distance learning, home study, correspondence, television courses, or courses taken for audit do not fulfill the eligibility requirements that the student actively attend classes. The online restriction does not apply to students who are completing their degree requirements while engaged in practical training.

Coverage for Dependents

Eligible individuals may also insure, on a Voluntary Participation Basis, their eligible Dependents. Individuals who enroll their dependents must enroll them within 31 days of the Insured Student's enrollment in the plan with the exception of adopted children or newborn children (see the Certificate provision entitled **Dependent Child Coverage**). They will be enrolled for the same term of coverage for which the Insured Student enrolls. Dependents of an **Eligible International Student** must possess a valid passport and a proper Visa (either an F-2, J-2 or M-2 visa).

How Do I Waive/Enroll?

You must enroll in the student health insurance plan offered at The Master's University and Seminary unless you have comparable coverage. If you have an insurance plan with comparable coverage, you must provide proof of coverage through your online registration portal at the time of registration for classes. To enroll eligible dependents online, please visit www.jcbins.com.

Special Enrollment - Qualifying Life Event

You, and Your Spouse or Child can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other health plan due to:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated for You or Your Dependent's Coverage; or
7. A Child no longer qualifies for coverage as a Child under the other health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

In addition, You, and Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following event:

1. You or Your Spouse or Child lose eligibility for Medi-Cal or a state child health plan.
2. You or Your Spouse or Child become eligible for Medi-Cal or a state child health plan.

We must receive notice and Premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

Make your elections by contacting John C Breckenridge Insurance Solutions at **http://jcbins.com/** to request an Enrollment form.

Effective Dates & Costs

All time periods begin at 12:00 A.M. local time and end at 11:59 P.M. local time at the Policyholder's address.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Fall	8/1/18	1/9/19	9/11/18
Spring	1/10/19	7/31/19	1/19/19

Rates for Undergraduate, Domestic and International students and Dependents
Dependent rates are in addition to the student rate.

	Fall	Spring
Student	$1,001	$1,254
Spouse*	$1,001	$1,254
Each Child*	$1,001	$1,254
3 or more Children*	$3,003	$3,762

The above rates include an administrative service fee

Effective Dates: Insurance under the Certificate will become effective on the later of:

1. The Policy Effective Date;
2. The beginning date of the term for which premium has been paid;
3. The day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed;
5. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

Dependent's coverage, under the Voluntary Participation Basis, becomes effective on the later of:

1. The day after the date of postmark when the Enrollment Form is mailed; or
2. The beginning date of the term for which premium has been paid; or
3. The day after the date the required individual Enrollment Form and premium payment are received by Us or Our authorized agent. This applies only when premium payment is made within 31 days of Your enrollment in the School's insurance plan; or
4. The Policy Effective Date.

The enrollment Period will run from the start of the quarter or semester for which coverage is desired.

Termination of Benefits

Termination Dates: Your insurance will terminate on the earliest of:

1. The date the Certificate terminates for all Insured Persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date You cease to be eligible for the insurance; or
4. The date You enter military service or
5. For International Students, the date they cease to meet Visa requirements; or
6. For International Students, the date they depart the Country of Assignment for his/her Home Country (except for scheduled school breaks); or
7. On any premium due date the Policyholder fails to pay the required premium for You except as the result of an inadvertent error and subject to any Grace Period provision.

Refund of Premium

Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:

1. For any student who does not attend school during the first thirty-one (31) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium will be made minus any claims paid.
2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made for such person upon written request received by Us within 90 days of withdrawal from school.
3. For International Students and/or their covered Dependents. We will refund a pro rata portion of the premium actually paid (less any claims paid) for any individual who:
   - Withdraws from School during their first semester; and
   - Returns to their Home Country on a permanent basis.

   A written request must be sent to us within 60 days of such departure.

No other refunds will be allowed.

Extension of Benefits

Coverage under the Certificate ceases on the Termination Date. However, coverage for You will be extended as follows:

1. If You are Hospital Confined for Covered Injury or Covered Sickness on the date Your insurance terminates, we will continue to pay benefits for up to 90 days from the Termination Date while such Confinement continues.

Dependents that are newly acquired during Your Extension of Benefits period are not eligible for benefits under this provision.

Definitions

These are key words used in the Certificate. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Certificate is read.

Accident means a sudden, unforeseeable external event which directly and from no other cause results in an Injury to the Insured Person.

Ambulance Service means transportation to and from a Hospital or facility by a licensed Ambulance whether a ground, air or water Ambulance, in a Medical Emergency or non-medical emergency.

Ambulatory Surgical Center means a facility which meets licensing and other legal requirements and which:

1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed Registered Nurse at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has x-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and

8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

Anesthetist means a Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Assistant Surgeon means a Physician who assists the Surgeon who actually performs a surgical procedure.

Brand-Name Prescription Drug means a Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.

Certificate: The Certificate issued by Us, including the Schedule of Benefits and any attached riders.

Coinsurance means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

Complications of Pregnancy means conditions that require Hospital Confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Confinement/Confined means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a seventy-two (72) hour period, will be considered a continuation of the Confinement. Confinement does not include observation, which is a review or assessment of eighteen (18) hours or less, of an Insured Person's condition that does not result in admission to a Hospital or health care facility.

Copayment means a specified dollar amount You must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

Covered Injury or Injury means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. All Injuries sustained in any one (1) Accident, all related conditions and recurrent symptoms of these Injuries are considered a single Injury.

Covered Medical Expense means those Medically Necessary charges for any Treatment, service or supplies that are:

1. Not in excess of the Usual and Reasonable charges therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Preferred Allowance; and
4. Incurred while Your Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means an illness, disease or condition including pregnancy and Complications of Pregnancy that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Custodial Care means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

Deductible means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

Dependent means:
1. An Insured Student's lawful spouse or lawful Domestic Partner;
2. An Insured Student's dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is:
    a. primarily dependent upon the Insured Student for support and maintenance; and
    b. incapable of self-sustaining employment by reason of intellectual disability or physical handicap.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Domestic Partner means two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
3. Both persons are at least 18 years of age, except as provided in Section 297.1.
4. Either of the following:
    a. Both persons are members of the same sex.
    b. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in Section 402(a) of Title 42 of the United States Code for old-age insurance benefits or Title XVI of the Social Security Act as defined in Section 1381 of Title 42 of the United States Code for aged individuals. Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over 62 years of age.
5. Both persons are capable of consenting to the domestic partnership.

Any references herein to spouse and marriage include domestic partners and domestic partnerships.

Durable Medical Equipment means a device which:
1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
5. Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.

Durable Medical Equipment does not include:
1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. Equipment that may increase the value of Your residence.

Effective Date means the date coverage becomes effective.

Elective Surgery or Elective Treatment means those health care services or supplies not medically necessary for the care and Treatment of a Covered Injury or Covered Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Eligible Student means a student who meets all eligibility requirements of the School named as the Policyholder or Dependent of the Insured Student.

Emergency Medical Condition means a Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

Essential Health Benefits mean benefits that are defined in Section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of covered services:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitative and Habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Experimental/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see the Medically Necessary/Medical Necessity provision.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes the type of drug and tier status.

Gender Dysphoria means a conflict between Your physical gender and the gender with which You identify. The identity conflict must continue over at least 6 months and You must meet the definition of Gender Dysphoria as described by the American Psychiatric Association.

Generic Prescription Drug means any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

Habilitation/Habilitative Services means health care services and devices that help Your keep, learn, or improve skills and functions for daily living. Examples include therapy for a child who is not walking or talking at the expected age. Habilitative Services may include such services as Physical Therapy, occupational therapy, and speech- language pathology, and other services for Insured Persons with disabilities in a variety of inpatient and outpatient settings, or both. Habilitative Services shall be covered under the same terms and conditions applied to Rehabilitative services under the Certificate.

Home Country means Your country of citizenship. If You have dual citizenship, Your Home Country is the country of the passport You used to enter the United States. Your Home Country is considered the Home Country for any Dependent of Yours while insured under the Certificate.

Home Health Care Agency means an agency that:

1. is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. is engaged primarily in providing skilled nursing facility services and other therapeutic services in the Insured Person's Home under the supervision of a Physician or a Nurse; and
3. maintains clinical records on all patients.

Home Health Care means the continued care and treatment of an Insured Person if:

1. institutionalization of the Insured Person would have been required if Home Health Care was not provided; and
2. the Insured Person's physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
    a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
    b. a public or private health service or agency that is licensed as a Home Health Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

Hospice means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

Hospital means a facility which provides diagnosis, Treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax- supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include Rehabilitative facilities if such is specifically required for Treatment of physical disability.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

Immediate Family Member means You and Your spouse or the parent, child, brother or sister of You or Your spouse.

Insured Person means an Insured Student or Dependent of an Insured Student while insured under the Certificate.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under the Certificate.

International Student means an international student:

2. With a current passport and a student Visa;
3. Who is temporarily residing outside of his or her Home Country; and
4. Is actively engaged, as a student or in educational research activities through the Policyholder.

In so far as the Certificate is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

Loss means medical expense caused by an Injury or Sickness which is covered by the Certificate.

Medically Necessary or **Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide to an Insured Person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured Person's illness, injury or disease; and
3. not primarily for the convenience of the Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of that Insured Person's illness, injury or disease.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Mental Health Disorder means a mental health condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization. Mental Health Disorders include Severe Mental Illnesses of an Insured Person of any age and Serious Emotional Disturbances of a Child.

Non-Preferred Providers have not agreed to any pre-arranged fee schedules.

Non-Preferred Drug means a drug that makes up the formulary drug list and may have a higher out-of-pocket cost.

Nurse means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:

1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

Organ Transplant means the moving of an organ from one body to another or from a donor site to another location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

Out-of-Pocket Maximum means the most You will pay during a Policy Year before Your coverage begins to pay 100% of the allowed amount. This limit will never include premium, balance-billed charges or health care the Certificate does not cover. Your Non-Preferred Provider payments or other non-covered expenses do not count toward this limit.

Orthotic Devices means rigid or semi-rigid devices supporting a weak or deformed leg, foot, arm, hand, back or neck or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Benefits for Orthotic Devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An Orthotic Device differs from a prosthetic in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. Orthotic Devices are usually customized for an Insured Person's use and are not appropriate for anyone else. Examples of Orthotic Devices include but are not limited to ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO).

Physical Therapy means any form of the following:

1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under the Certificate, and who is not:

1. The Insured Person;
2. An Immediate Family Member; or
3. A person employed or retained by the Insured Person.

Preadmission Testing means tests done in conjunction with and within 5 days of a scheduled surgery where an operating room has been reserved before the tests are done.

Preferred Allowance means the amount a Preferred Provider will accept as payment in full or Covered Medical Expenses.

Preferred Drug means a formulary drug that is within a select subset of therapeutic classes, which make up the formulary drug list.

Preferred Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Prosthetic Devices (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for Prosthetic Devices include coverage of devices that replace all or part of a permanently inoperative or malfunctioning body part and are furnished on a Physician's order. This benefit also covers prosthetic devices for post laryngectomy. Examples of Prosthetic Devices include but are not limited to pacemakers, intraocular lenses, cochlear implants, osseo integrated hearing devices, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Qualifying Life Event means an event that qualifies a Student to apply for coverage for him/herself or for the Insured Student's Dependent due to a Qualifying Life Event under the Certificate.

Rehabilitative means the process of restoring Your ability to live and work after a disabling condition by:

1. Helping You achieve the maximum possible physical and psychological fitness;
2. Helping You regain the ability to care for yourself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

Reservist means a member of a reserve component of the Armed Forces of the United States. Reservists also include a member of the State National Guard and the State Air National Guard.

School or College means the college or university attended by the Insured Student.

Serious Emotional Disturbances of a Child means a child who:

1. Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and
2. Who meets the criteria in paragraph (2) of the subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Severe Mental Illnesses includes schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

Skilled Nursing Facility – a facility, licensed, and operated as set forth in applicable state law, which:

1. mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury;
2. provides daily skilled care given by, or under the direct supervision of, skilled nursing or therapy staff
2. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;

3. is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
4. is not a rest, educational, or custodial facility or similar place.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical Treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Student Health Center or Student Infirmary means an on-campus facility that provides:
1. Medical care and Treatment to Sick or Injured students; and
2. Nursing services.

A Student Health Center or Student Infirmary does not include:
1. Medical, diagnostic and Treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

Surgeon means a Physician who actually performs surgical procedures.

Telemedicine means the practice of health care delivery, diagnosis, consultation, Treatment, transfer of medical data, and education using interactive audio, video, or data communications involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information. Neither a telephone conversation nor an electronic mail message between a Physician and Insured Person constitutes "Telemedicine".

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

Urgent Care means short-term medical care performed in an Urgent Care Facility for non-life-threatening conditions that can be mitigated or require care within forty-eight (48) hours of onset.

Urgent Care Facility means a Hospital or other licensed facility which provides diagnosis, Treatment, and care of persons who need acute care under the supervision of Physicians.

Usual and Reasonable means the average charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a:
1. Like service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.

You, or Your(s) means an Insured Person, Insured Student, or Dependent of an Insured Student while insured under the Certificate.

Visa means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid visa, either an F-1 (Academic), J-1 (Exchange) or M-1(Vocational) in order to continue as a student in the United States.

We, **Us**, or **Our** means Commercial Casualty Insurance Company or its authorized agent. Also referred to as the Company.

Preferred Provider Organization (PPO) Network

By enrolling in this Insurance Program, you have the Cigna Open Access Plus (OAP) Network of participating Providers with access to quality health care at discounted fees. To find a complete listing of the Network's participating Providers, go to www.cigna.com, or contact Consolidated Health Plans toll-free at (877) 657-5030, or www.chpstudenthealth.com for assistance.

Benefit Payments for Preferred Providers and Non-Preferred Providers
The Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. The Certificate provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

Upon Your request, We will provide coverage to the completion of treatment by a Preferred Provider whose contract has been terminated, for certain conditions, if the Provider and We agree on terms and reimbursement. We will also provide coverage to the completion of Treatment by a Non-Preferred Provider if You are a new enrollee under similar circumstance.

Treatment will be continued to completion of service for the following conditions:
1. An acute condition – for the duration of the acute condition;
2. Serious Chronic Condition – for the period necessary to complete a course of treatment and to arrange for a safe transfer to another Provider, not to exceed twelve (12) months from the contract termination or 12 months from the effective date of coverage for a newly covered enrollee;
3. Three trimesters of pregnancy and the immediate postpartum period - for the duration of the pregnancy.
4. A terminal illness – for the duration of the terminal illness, which may exceed 12 months from the contract termination date of 12 months from the effective date of coverage for a new enrollee
5. Care of a newborn Child between birth and 36 months of age- 12 months from the contract termination date or 12 months from the effective date of coverage for a new enrollee;
6. Surgery or other procedure that recommended and documented by the Provider - to take place within 180 days of the contract's termination date or within 180 days of the effective date of coverage for a newly covered enrollee

We shall notify You of the termination of the Preferred Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, we shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining and alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment.

Schedule of Benefits

MASTER'S UNIVERSITY & SEMINARY
SCHEDULE OF BENEFITS
Actuarial Value: 83.89%
Metal Tier: Gold

Preventive Services:
Preferred Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Preferred Allowance when services are provided through a Preferred Provider.

Non-Preferred Provider: The Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Preferred Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Preferred Provider are applied toward the annual Out-of-Pocket Maximum. Benefits are paid at 60% of the Usual and Reasonable charge.

Deductible:			
	Preferred Provider:	Individual:	$250
	Non-Preferred Provider:	Individual:	$250
Out of Pocket Maximum	Preferred Provider	Individual:	$6,600
		Family:	$13,200
	Non-Preferred Provider	Individual:	$6,600
		Family:	$13,200
Coinsurance Amount:			
	Preferred Provider:	80% of Preferred Allowance for Covered Medical Expenses unless otherwise stated below.	
	Non-Preferred Provider:	60% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.	

Pre-Certification Process
You or your Provider is responsible for calling Us at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services or surgery, the call should be made at least 5 working days prior to Hospital Confinement or surgery. In the case of an emergency, the call should take place as soon as reasonably possible.

The following Inpatient and Outpatient services require Pre-Certification:
1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of substance abuse, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Inpatient Surgery
4. Physical Therapy (Outpatient) precertification required after the 5th visit.
5. Occupational Therapy (Outpatient) precertification required after the 5th visit.
6. Chiropractic Services (Outpatient) precertification required after the 5th visit.

If you or your Provider fails to call there will not be any penalty to you.

Please refer to the Pre-Certification Process in the Certificate for further information.

Benefit Payment for Preferred Providers and Non-Preferred Providers
This policy provides benefits based on the type of health care provider selected. This Policy provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

Preferred Provider Organization:
To locate a Preferred Provider in Your area, consult Your Provider Directory or call toll free (877) 657-5030 or visit Our website at www.cigna.com

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:
1. **THOSE SERVICES LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A PREFERRED OR NON-PREFERRED PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW, THE MEDICAL PLAN DEDUCTILBE WILL ALWAYS APPLY**

BENEFITS FOR COVERED INJURY/SICKNESS	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Inpatient Benefits		
Hospital Room & Board Expenses Pre-Certification Required. Pre-Certification is not required for medical emergency, Urgent Care or Hospital confinement for maternity care prior to the initial 48 hours following vaginal delivery/96 hours following cesarean section or for in-patient length of state following mastectomy and reconstructive surgery where the length of stay is determined by the physician or surgeon in consultation with the patient.	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Hospital Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma.	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Preadmission Testing	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Physician's Visits while Confined	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Inpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 80% of the Preferred Allowance 80% of the Preferred Allowance 80% of the Preferred Allowance	 60% of Usual and Reasonable Charge 60% of Usual and Reasonable Charge 60% of Usual and Reasonable Charge
Registered Nurse Services for private duty nursing while Confined	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Physical Therapy (inpatient)	80% of the Preferred Allowance	60% of Usual and Reasonable Charge Copayment: $20
Skilled Nursing Facility Expense Benefit Up to 100 days per benefit period	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Treatment for Mental Health, Substance Abuse, Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism	80% of Preferred Allowance	60% of Usual and Reasonable Charge

Outpatient Benefits		
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 80% of the Preferred Allowance 80% of the Preferred Allowance 80% of the Preferred Allowance	 60% of Usual and Reasonable Charge 60% of Usual and Reasonable Charge 60% of Usual and Reasonable Charge
Outpatient Surgery Expenses (excluding not-scheduled surgery) –for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Habilitation and Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, Physical Therapy, occupational therapy and speech therapy	80% of the Preferred Allowance Copayment: $20 Deductible Waived For Physical Therapy and Occupational Therapy precertification required after the 5th visit	60% of Usual and Reasonable Charge Copayment: $20 Deductible Waived
Emergency Services Expenses	80% of the Preferred Allowance	80% of the Preferred Allowance
In Office Physician's Visits primary Physician, specialist, consultant and any other licensed practitioner operating within the scope of his or her license	80% of the Preferred Allowance Copayment: $20 Deductible waived	60% of Usual and Reasonable Charge Copayment: $20 Deductible waived
Second Opinion Benefit	80% of the Preferred Allowance Copayment: $20	60% of Usual and Reasonable Charge Copayment: $20
Urgent Care Centers or Facilities	100% of the Preferred Allowance Copayment: $20 Deductible Waived	60% of Usual and Reasonable Charge Copayment: $20 Deductible Waived
Outpatient Facility Fee	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Diagnostic Imaging Services	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
CT Scan, MRI and/or PET Scans	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Laboratory Procedures (Outpatient)	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Shots and Injections unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit Up to $200 maximum per Policy Year	80% of the Preferred Allowance	60% of Usual and Reasonable Charge

Prescription Drugs Retail Pharmacy The Pharmacy Benefits Manager (PBM) is: BeRx – Prescriptions and over-the-counter preventive medications recommended by the United States Preventive Services Task Force (USPTF) will be covered without cost-sharing when prescribed by a physician.		
Generic	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment waived for Generic Contraceptives and brand-name contraceptives for which there are no therapeutic equivalent. Up to a 12-month supply of contraceptives may be dispensed with a single prescription order. Copayment: $10 Deductible waived	
Preferred Drug	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: $25 Deductible waived	
Non-Preferred Drug	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: $50 Deductible waived	
Specialty Prescription Drugs	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: $50 Deductible waived	
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Home Health Care Expenses Up to 100 visits per Policy Year (separate visit limits apply for Habilitative and Rehabilitative Services	80% of the Preferred Allowance Copayment: $20	60% of Usual and Reasonable Charge Copayment: $20
Hospice Care Coverage	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Treatment for Mental Health, Substance Abuse, Gender Dysphoria and Behavioral Health Treatment for Pervasive Developmental Disorder or Autism	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Private Duty Nursing by a Registered Nurse	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Other Benefits		
Allergy Testing	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Allergy Injections/Treatment	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Ambulance Service ground and/or air/water transportation	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Braces and Appliances	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Prosthetic and Orthotic Devices	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Durable Medical Equipment	80% of the Preferred Allowance	60% of Usual and Reasonable Charge

Dialysis Treatment	80% of the Preferred Allowance	60% of Usual and Reasonable
Maternity Benefit	Same as any other Covered Sickness Preventive Services associated with Prenatal Care and the First Postpartum Appointment will be covered with no Cost sharing.	
Routine Newborn Care	Same as any other Covered Sickness	
Nutritional Counseling Limited to 6 visits per Policy Year	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Accidental Injury Dental Treatment for Insured Person's over age 18	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Dental Services in Preparation for Radiation Therapy Benefit	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Abortion Expense	80% of the Preferred Allowance Copayment: $20	60% of Usual and Reasonable Charge Copayment: $20
Non-emergency Care While Traveling Outside of the United States Charges do not apply to the Out of Pocket Maximum	60% of Usual and Reasonable Charge Subject to $1,000 maximum per Policy Year	
Medical Evacuation Expense	100% of Usual and Reasonable Charge	
Repatriation Expense	100% of Usual and Reasonable Charge	
Pediatric Dental Care Benefit Coverage is limited to covered persons through the end of the month in which they turn 19 Diagnostic and preventive care (Type A services) Limited to 1 dental exams every 6 months. *The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:* Basic Restorative Care (Type B Services) Major Restorative Care (Type C Services) Orthodontic Services (Medically Necessary)	100% of Usual and Reasonable Charge for Preventive Dental Care 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable	

Dental benefits are subject to the medical plan's **deductibles** and **maximum out-of-pocket limits** as explained on the schedule of benefits.

Diagnostic and preventive care (type A services)

- D0120 Periodic oral exam
- D0140 Limited oral evaluation - problem focused
- D0145 Oral evaluation - child under 3
- D0150 Comprehensive oral exam
- D0160 Detailed and extensive oral evaluation - by report
- D0170 Reevaluation - limited, problem focused
- D0180 Comprehensive periodontal evaluation
- D0210 Complete full mouth images
- D0220 Periapical - first image

- D0230 Periapical - each additional image
- D0260 Extraoral - each additional radiographic image
- D0270 Bitewing - single image
- D0272 Bitewing - two images
- D0273 Bitewing – three images
- D0274 Bitewing - four images
- D0277 Vertical bitewings - 7 to 8 images
- D0290 Posterior - anterior or lateral skull and facila bone survey radiographic image
- D0310 Sialography
- D0320 TMJ arthrogram, including injection
- D0322 Tomographic survey
- D0330 Panoramic image (once in a 36-month period per **provider**)
- D0340 2D cephalometric radiographic image – acquisition, measurement and analysis
- D0350 2D oral/facial photographic image obtained intra-orally or extra-orally
- D0502 Other oral pathology procedures, by report
- D0999 Unspecified diagnostic procedure, by report
- D1110 Prophylaxis - adult (2 per year)
- D1120 Prophylaxis - child (2 per year)
- D1206 Topical fluoride varnish (2 per year)
- D1208 Topical application of fluoride - excluding varnish (2 per year)
- D1351 Sealant - per tooth (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1352 Preventive resin restoration - permanent (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1353 Sealant repair - per tooth
- D1354 Interim caries arresting medicament application (for 1st, 2nd & 3rd, permanent molars - no limit)
- D1510 Space maintainer - fixed - unilateral
- D1515 Space maintainer - fixed - bilateral
- D1520 Space maintainer - removable - unilateral
- D1525 Space maintainer - removable - bilateral
- D1550 Recementation of space maintainer
- D1555 Removal of fixed space maintainer
- D1575 Distal shoe space maintainer – fixed – unilateral
- D2990 Resin infiltration of lesion (once per tooth every 3 years, permanent molars only)
- D4346 Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation
- D9110 Palliative treatment of dental pain, minor

Basic restorative care (type B services)

- D0240 Occulusal image
- D0250 Extra-oral – 2D projection radiographic image
- D0251 Extra-oral posterior dental radiographic image
- D2140 Amalgam - 1 surface
- D2150 Amalgam - 2 surfaces
- D2160 Amalgam - 3 surfaces
- D2161 Amalgam - 4 or more surfaces
- D2330 Resin - 1 surface - anterior
- D2331 Resin - 2 surfaces - anterior
- D2332 Resin - 3 surfaces - anterior
- D2335 Resin - 4 or more surfaces - anterior
- D2390 Resin - based composite crown, anterior
- D2391 Resin one surface - posterior
- D2392 Resin - two surfaces - posterior
- D2393 Resin - three surfaces - posterior
- D2394 Resin - four or more surfaces - posterior

- D2910 Recement or re-bond inlay, onlay, veneer or partial coverage restoration
- D2915 Recement or re-bond indirectly fabricated or prefabricated post and core
- D2920 Recement crown
- D2921 Reattachment of tooth fragment, incisal edge or cusp
- D2929 Prefabriated porcelain/ceramic crown - primary tooth
- D2930 Stainless steel crown - primary
- D2931 Stainless steel crown - permanent
- D2932 Prefabricated resin crown
- D2933 Stainless steel crown with resin window
- D2934 Prefabricated stainless crown - primary tooth
- D2940 Protective restoration
- D2941 Interim therapeutic restoration – primary dentition
- D2951 Pin retention - per tooth in addition to restoration
- D2970 Temporary crown (fractured tooth)
- D2999 Unspecified restorative procedure, by report
- D3110 Pulp cap - direct
- D3120 Pulp cap - indirect
- D3220 Pulpotomy (therapeutic)
- D3221 Gross pulpal debridement primary and permanent
- D3222 Partial pulpotomy for apexogensis
- D3230 Pulpal therapy - anterior primary tooth
- D3240 Pulpal therapy - posterior primary tooth
- D3310 Root canal - anterior excluding final restoration
- D3320 Root canal - bicuspid excluding final restoration
- D3331 Treatment of root canal obstruct-non surgical access
- D3332 Incomplete endodontic therapy inoperable or fractured tooth
- D3333 Internal root repair of perforation defects
- D3346 Retreatment-root canal treatment - anterior
- D3347 Retreatment-root canal treatment - bicuspid
- D3351 Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3352 Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, pulp space disinfection, etc.)
- D3353 Apexification/recalcification - final
- D3355 Pulpal regeneration - initial visit
- D3356 Pulpal regeneration – interim medication replacement
- D3357 Pulpal regeneration – completion of treatment
- D3410 Apicoectomy - anterior
- D3421 Apicoectomy- bicuspid (first root)
- D3425 Apicoectomy- molar (first root)
- D3426 Apicoectomy- each additional root
- D3427 Periradicular surgery without apicoectomy
- D3430 Retrograde filling - per root
- D3450 Root amputation - per root
- D3920 Hemisection - not including root canal therapy
- D4210 Gingivectomy/gingivoplasty, 4+ teeth (1 per quadrant/tooth every 3 years)
- D4211 Gingivectomy/gingivoplasty, 1 To 3 teeth (1 per quadrant/tooth every 3 years)
- D4212 Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth (1 per quadrant/tooth every 3 years)
- D4240 Gingival flap –with root planing, 4 or more contiguous teeth (1 per quadrant/tooth every 3 years)
- D4241 Gingival flap - includes root planing, 1-3 teeth (1 per quadrant/tooth every 3 years)
- D4245 Apically positioned flap
- D4268 Surgical revision procedure per tooth

- D4341 Periodontal scaling and root planing, 4 or more teeth per quadrant (1 per quadrant every 2 rolling years)
- D4342 Periodontal scaling and root planing, 1-3 teeth (1 per separate quadrant every 2 rolling years)
- D4910 Periodontal maintenance - procedures (2 per **calendar year** following active periodontal treatment)
- D4920 Unscheduled dressing change (by someone other than treating **dentist** or their staff)
- D4999 Unspecified periodontal procedure, by report
- D5731 Reline complete mandibular denture (chairside)
- D5740 Reline maxillary partial denture (chairside)
- D5860 Overdenture – complete, by report
- D6053 Implant/Abutment supported removable denture for completely edentulous arch By Report
- D6054 Implant/Abutment supported removable denture for partially edentulous arch By Report
- D6078 Implant/Abutment supported fixed denture for completely edentulous arch By Report
- D6079 Implant/Abutment supported fixed denture for partially edentulous arch By Report
- D6092 Recement implant/abutment supported crown
- D6093 Recement implant/abutment supported partial
- D6930 Recement or re-bond fixed partial denture retainers
- D7111 Extract coronal remnants - deciduous tooth
- D7140 Extraction - erupted tooth or exposed root
- D7210 Surgical removal of erupted tooth
- D7220 Removal of impacted tooth - soft tissue
- D7250 Surgical removal of residual tooth roots
- D7260 Oroantral fistula closure
- D7261 Primary closure of a sinus perforation
- D7270 Tooth re-implantation of accidental displaced tooth
- D7272 Tooth transplantation
- D7280 Surgical access of unerupted tooth
- D7282 Mobilization of erupted or malpositioned tooth to aid eruption
- D7283 Device to aid eruption of impacted tooth
- D7285 Incisional biopsy of oral tissue-hard (bone/tooth)
- D7286 Incisional biopsy of oral tissue-soft
- D7310 Alveoloplasty in conjunction with extraction
- D7311 Alveoloplasty in conjunction with extraction, 1-3 teeth
- D7320 Alveoloplasty not in conjunction with extraction
- D7321 Alveoloplasty not in conjunction with/extraction, 1-3 teeth
- D7450 Removal of odontogenic cyst/tumor up to 1.25 cm
- D7451 Removal of odontogenic cyst/tumor greater than 1.25 cm
- D7471 Removal of lateral exostosis (maxilla or mandible)
- D7472 Removal of torus palatinus
- D7473 Removal of torus mandibularis
- D7485 Surgical reduction of osseous tuberosity
- D7510 Incision and drainage of abscess intraoral
- D7511 Incision and drainage of abscess - intraoral soft tissue, complex
- D7520 Incision and drainage of abscess - extraoral, soft tissue
- D7521 Incision and drainage- extraoral complex
- D7530 Removal foreign body, mucosa, skin, tissue
- D7540 Removal of reaction producing foreign body
- D7550 Partial ostectomy/sequestrectomy
- D7910 Suture of recent small wound less than 5 cm
- D7960 Frenulectomy
- D7963 Frenuloplasty
- D7970 Excision of hyperplastic tissue - per arch
- D7971 Excision of pericoronal gingiva

- D7972 Surgical reduction of fibrous tuberosity
- D7999 Unspecified oral surgery procedure
- D9410 House call
- D9430 Office visit for observation (during regular hours)
- D9440 Office visit after hours
- D9930 Treatment of complications post-surgical
- D9950 Occlusial analysis
- D9951 Occlusial adjustment - limited
- D9952 Occlusial adjustment - complete
- D3999 Unspecified endodontic procedure, by report
- D7911 Complicated suture - up to 5 cm
- D7912 Complicated suture - greater than 5 cm

Major restorative care (type C services)

- D2510 Inlay - metallic - 1 surface (1 per tooth every 5 years)
- D2520 Inlay - metallic - 2 surfaces (1 per tooth every 5 years)
- D2530 Inlay - metallic - 3 or more surfaces (1 per tooth every 5 years)
- D2542 Onlay - metallic - 2 surfaces (1 per tooth every 5 years)
- D2543 Onlay - metallic - 3 surfaces (1 per tooth every 5 years)
- D2544 Onlay - metallic - 4 or more surfaces (1 per tooth every 5 years)
- D2610 Inlay - porcelain/ceramic - 1 surface (1 per tooth every 5 years)
- D2620 Inlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
- D2630 Inlay - porcelain/ceramic - 3 or more surfaces (1 per tooth every 5 years)
- D2642 Onlay - porcelain/ceramic - 2 surfaces (1 per tooth every 5 years)
- D2643 Onlay - porcelain/ceramic - 3 surfaces (1 per tooth every 5 years)
- D2644 Onlay - porcelain/ceramic - in addition to inlay (1 per tooth every 5 years)
- D2650 Inlay - composite/resin - 1 surface (1 per tooth every 5 years)
- D2651 Inlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
- D2652 Inlay - composite/resin - 3 surfaces (1 per tooth every 5 years)
- D2662 Onlay - composite/resin - 2 surfaces (1 per tooth every 5 years)
- D2663 Onlay - composite/resin - 3 surface (1 per tooth every 5 years)
- D2664 Onlay - composite/resin - 4 or more surfaces (1 per tooth every 5 years)
- D2710 Crown - resin-based composite, indirect (1 per tooth every 5 years)
- D2712 Crown – ¾ resin-based composite, indirect (1 per tooth every 5 years)
- D2720 Crown - resin with high noble metal (1 per tooth every 5 years)
- D2721 Crown - resin with predominantly base metal (1 per tooth every 5 years)
- D2722 Crown - resin with noble metal (1 per tooth every 5 years)
- D2740 Crown - porcelain/ceramic substrate (1 per tooth every 5 years)
- D2750 Crown - porcelain fused high noble metal (1 per tooth every 5 years)
- D2751 Crown -porcelain fused predominantly base metal (1 per tooth every 5 years)
- D2752 Crown - porcelain fused to noble metal (1 per tooth every 5 years)
- D2780 Crown - 3/4 cast high noble metal (1 per tooth every 5 years)
- D2781 Crown -3/4 cast predominantly base metal (1 per tooth every 5 years)
- D2782 Crown - 3/4 cast noble metal (1 per tooth every 5 years)
- D2783 Crown – ¾ porcelain/ceramic (1 per tooth every 5 years)
- D2790 Crown - full cast high noble metal (1 per tooth every 5 years)
- D2791 Crown - full cast predominantly based metal (1 per tooth every 5 years)
- D2792 Crown - full cast noble metal (1 per tooth every 5 years)
- D2794 Crown - titanium (1 per tooth every 5 years)
- D2950 Core buildup, including any pins when required
- D2952 Cast post and core in addition to crown
- D2953 Cast post - each Additional - same tooth
- D2954 Prefab post and core in addition to crown

- D2957 Prefabricated post - each add - same tooth
- D2960 Labial veneer – chairside (1 per tooth every 5 years)
- D2961 Labial veneer -lab (1 per tooth every 5 years)
- D2962 Labial veneer porcelain – lab (1 per tooth every 5 years)
- D2971 Additional procedures - new crown under partial
- D2980 Crown repair
- D2981 Inlay repair - material failure
- D2982 Onlay repair - material failure
- D2983 Veneer repair - material failure
- D3330 Root canal treatment - molar excluding final restoration
- D3348 Retreatment - root canal treatment - molar
- D4249 Clinical crown lengthening hard tissue
- D4260 Osseous surgery, including elevation of a full thickness flap and closure – four or more contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4261 Osseous surgery, including elevation of a full thickness flap and closure – 1 to 3 contiguous teeth or tooth bounded spaces per quadrant (1 per quadrant/tooth every 3 years)
- D4270 Pedicle soft tissue graft procedure
- D4273 Connective tissue graft procedures, including donor and recipient surgical sites - first tooth, implant, or edentulous tooth position in graft
- D4275 Non-autogenous connective tissue graft, including recipient site and donor material - first tooth, implant, or edentulous tooth position in graft
- D4276 Connective tissue/pedicle graft - tooth
- D4277 Free soft tissue graft procedure, including recipient and donor surgical site - first tooth, implant, or edentulous tooth position in graft
- D4278 Free soft tissue graft procedure, including recipient and donor surgical sites - each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4283 Autogenous connective tissue graft procedure, including donor and recipient surgical sites – each additional contiguous tooth, implant or edentulous tooth position in same graft site
- D4285 Non-autogenous connective tissue graft procedure, including recipient surgical site and donor material – each additional contiguous tooth, implant or edentulous tooth position in same graft site

- D4355 Full mouth debridement (1 per lifetime)
- D5110 Complete denture - maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5120 Complete denture - mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5130 Immediate denture – maxillary (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5140 Immediate denture – mandibular (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5211 Maxillary partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5212 Mandibular partial denture - resin base (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5213 Maxillary partial denture - cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5214 Mandibular partial denture cast base (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5221 Immediate maxillary partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5222 Immediate mandibular partial denture – resin base, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)

- D5223 Immediate maxillary partial denture – cast metal framework with resin denture bases, including any conventional clasps, rests and teeth. Includes limited follow-up care only; does not include future rebasing (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5224 Immediate mandibular partial denture – cast metal framework with resin denture bases, including any conventional clasps, rests and teeth (1 every 5 years - all adjustments made for six months after the date of service, by the same **provider**, are included in the fee for this procedure)
- D5225 Maxillary partial denture – flexible base (1 every 5 years)
- D5226 Mandibular partial denture – flexible base (1 every 5 years)
- D5281 Removable unilateral partial denture (1 every 5 years)
- D5410 Adjustments maxillary complete denture (not eligible within 6 months of denture placement, then no limit)
- D5411 Adjustments mandibular complete denture (not eligible within 6 months of denture placement, then no limit)
- D5421 Adjustments partial denture - maxillary (not eligible within 6 months of denture placement, then no limit)
- D5422 Adjustments partial denture - mandibular (not eligible within 6 months of denture placement, then no limit)
- D5510 Repair broken complete denture base
- D5520 Replace missing or broken teeth, complete denture
- D5610 Repair resin denture base
- D5620 Repair cast framework
- D5630 Repair or replace broken clasp – per tooth
- D5640 Replace broken teeth - per tooth
- D5650 Add tooth to existing partial denture
- D5660 Add clasp to existing partial denture – per tooth
- D5670 Replace all teeth - upper partial
- D5671 Replace all teeth - lower partial
- D5710 Rebase complete maxillary denture (not eligible within 6 months of denture placement, then no limit)
- D5711 Rebase complete mandibular denture (not eligible within 6 months of denture placement, then no limit)
- D5720 Rebase partial maxillary denture (not eligible within 6 months of denture placement, then no limit)
- D5721 Rebase partial mandibular denture (not eligible within 6 months of denture placement, then no limit)
- D5730 Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5731 Reline complete mandibular denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5740 Reline complete maxillary denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5741 Reline complete mandibular partial denture, chairside (not eligible within 6 months of denture placement, then no limit)
- D5750 Reline complete maxillary denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5751 Reline complete mandibular denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5760 Reline maxillary partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5761 Reline mandibular partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)
- D5761 Reline mandibular partial denture, laboratory (not eligible within 6 months of denture placement, then no limit)

- D5820 Interim partial denture - upper (maxillary)
- D5821 Interim partial denture - lower (mandibular)
- D5850 Tissue conditioning, upper
- D5851 Tissue conditioning, lower
- D5863 Overdenture – complete maxillary (1 every 5 years)
- D5864 Overdenture - partial maxillary (1 every 5 years)
- D5865 Overdenture -complete mandibular (1 every 5 years)
- D5866 Overdenture – partial mandibular (1 every 5 years)
- D6010 Surgical placement of implant body endosteal implant
- D6013 Surgical placement of mini implant
- D6040 Surgical placement eposteal implant
- D6050 Surgical placement transosteal implant
- D6055 Dental implant supported connecting bar
- D6056 Prefabricated abutment
- D6057 Custom abutment
- D6058 Abutment supported porcelain/ceramic crown (1 every 5 years)
- D6059 Abutment supported porcelain fused metal crown high (1 every 5 years)
- D6060 Abutment supported porcelain fused metal crown base (1 every 5 years)
- D6061 Abutment supported porcelain fused metal crown noble (1 every 5 years)
- D6062 Abutment supported cast metal crown high noble (1 every 5 years)
- D6063 Abutment supported cast metal crown base noble (1 every 5 years)
- D6064 Abutment supported cast metal crown noble metal (1 every 5 years)
- D6065 Implant supported porcelain/ceramic crown (1 every 5 years)
- D6066 Implant supported porcelain fused metal crown high (1 every 5 years)
- D6067 Implant supported metal crown high (1 every 5 years)
- D6068 Abutment supported retainer for porcelain/ceramic (1 every 5 years)
- D6069 Abutment supported retainer for porcelain fused metal high (1 every 5 years)
- D6070 Abutment supported retainer for porcelain fused metal base (1 every 5 years)
- D6071 Abutment supported retained for porcelain fused metal noble (1 every 5 years)
- D6072 Abutment supported retained for cast metal full partial denture high (1 every 5 years)
- D6073 Abutment supported retainer for cast metal full partial denture base (1 every 5 years)
- D6074 Abutment supported retainer for cast metal full partial denture noble (1 every 5 years)
- D6075 Implant supported retainer for ceramic full partial denture (1 every 5 years)
- D6076 Implant supported retainer for porcelain fused metal high noble metal (1 every 5 years)
- D6077 Implant supported retainer for cast metal high (1 every 5 years)
- D6080 Implant maintenance procedures, when prostheses are removed and reinserted, including cleansing of prosthesis and abutments
- D6090 Repair implant supported prosthesis
- D6091 Replace precision attachment
- D6094 Abutment supported crown – titanium (1 every 5 years)
- D6095 Repair implant abutment prosthesis (1 every 5 years)
- D6100 Implant removal, by report (1 every 5 years)
- D6110 Implant/abutment supported removable denture for completely edentulous arch – maxillary (1 every 5 years)
- D6111 Implant/abutment supported removable denture for completely edentulous arch – mandibular (1 every 5 years)
- D6112 Implant/abutment supported removable denture for partially edentulous arch – maxillary (1 every 5 years)
- D6113 Implant/abutment supported removable denture for partially edentulous arch – mandibular (1 every 5 years)
- D6114 Implant/abutment supported fixed denture for completely edentulous arch – maxillary (1 every 5 years)

- D6115 Implant/abutment supported fixed denture for completely edentulous arch – mandibular (1 every 5 years)
- D6116 Implant/abutment supported fixed denture for partially edentulous arch – maxillary (1 every 5 years)
- D6117 Implant/abutment supported fixed denture for partially edentulous arch – mandibular (1 every 5 years)
- D6194 Abutment supported retainer crown for full partial denture (1 every 5 years)
- D6199 Unspecified implant procedure, by report
- D6205 Pontic - indirect resin based composite (1 every 5 years)
- D6210 Pontic - cast high noble metal (1 every 5 years)
- D6211 Pontic - cast predominantly base metal (1 every 5 years)
- D6212 Pontic - cast noble metal (1 every 5 years)
- D6214 Pontic – titanium (1 every 5 years)
- D6240 Pontic - porcelain fused to high noble (1 every 5 years)
- D6241 Pontic - porcelain fused to base metal (1 every 5 years)
- D6242 Pontic - porcelain fused to noble metal (1 every 5 years)
- D6245 Pontic - porcelain/ceramic (1 every 5 years)
- D6250 Pontic - resin with high noble metal (1 every 5 years)
- D6251 Pontic - resin with predominantly base metal (1 every 5 years)
- D6252 Pontic - resin with noble metal (1 every 5 years)
- D6545 Retainer - cast metal for resin bonded for fixed prosthesis (1 every 5 years)
- D6548 Retainer - porcelain/ceramic resin bonded for fixed prosthesis (1 every 5 years)
- D6600 Inlay – porcelain/ceramic, 2 surfaces (1 every 5 years)
- D6601 Inlay – porcelain/ceramic, 3 or more surfaces (1 every 5 years)
- D6602 Inlay - cast high noble metal, 2 surfaces major (1 every 5 years)
- D6603 Inlay - cast high noble metal, 3 or more surfaces (1 every 5 years)
- D6604 Inlay - cast predominately base metal 2 surfaces (1 every 5 years)
- D6605 Inlay - cast predominately base metal 3 or more surfaces (1 every 5 years)D6606 Inlay - cast noble metal, 2 surfaces (1 every 5 years)
- D6607 Retainer inlay - cast noble metal, three or more surfaces (1 every 5 years)
- D6608 Retainer onlay - porcelain/ceramic, 2 surfaces (1 every 5 years)
- D6609 Retainer onlay - porcelain/ceramic, 3 or more surfaces (1 every 5 years)
- D6610 Retainer onlay - cast high noble metal, 2 surfaces (1 every 5 years)
- D6611 Retainer onlay - cast high noble metal, 2 or more surfaces (1 every 5 years)
- D6612 Retainer onlay - cast predominantly base metal, 2 surfaces (1 every 5 years)
- D6613 Retainer onlay -cast predominantly base metal, 3 or more surfaces (1 every 5 years)
- D6614 Retainer onlay - cast noble metal, 2 surfaces (1 every 5 years)
- D6615 Retainer onlay - cast noble metal, 3 or more surfaces (1 every 5 years)
- D6624 Retainer inlay – titanium (1 every 5 years)
- D6634 Retainer onlay - titanium (1 every 5 years)
- D6710 Retainer crown - indirect resin based composite (1 every 5 years)
- D6720 Retainer crown - resin with high noble metal (1 every 5 years)
- D6721 Retainer crown - resin with predominantly base metal (1 every 5 years)
- D6722 Retainer crown - resin with noble metal (1 every 5 years)
- D6740 Retainer crown - porcelain/ceramic (1 every 5 years)
- D6750 Retainer crown - porcelain fused to high noble metal (1 every 5 years)
- D6751 Retainer crown - porcelain fused to predominantly base metal (1 every 5 years)
- D6752 Retainer crown - porcelain fused to noble metal (1 every 5 years)
- D6780 Retainer crown - 3/4 cast high noble metal (1 every 5 years)
- D6781 Retainer crown - 3/4 cast predominantly base metal (1 every 5 years)
- D6782 Retainer crown - 3/4 cast noble metal (1 every 5 years)
- D6783 Retainer crown - 3/4 porcelain/ceramic (1 every 5 years)
- D6790 Retainer crown - full cast high noble metal (1 every 5 years)

- D6791 Retainer crown - full cast predominantly base metal (1 every 5 years)
- D6792 Retainer crown - full cast noble metal (1 every 5 years)
- D6794 Retainer crown – titanium (1 every 5 years)
- D6940 Stress breaker
- D6980 Fixed partial denture repair
- D6985 Pediatric partial denture, fixed
- D6999 Unspecified fixed prosthodontic procedure, by report
- D7230 Removal of impacted tooth - partial bony
- D7240 Removal of impacted tooth - full bony
- D7241 Removal of impacted tooth - complication
- D7251 Coronectomy
- D7290 Surgical repositioning of teeth
- D7291 Transseptal fiberotomy, by report
- D7340 Vestibuloplasty - ridge extension (1 every 5 years)
- D7350 Vestibuloplasty - ridge extension including soft tissue grafts (once per arch)
- D7410 Excision of benign lesion up to 1.25 cm
- D7411 Excision of benign lesion more than 1.25 cm
- D7412 Excision of benign lesion, complicated
- D7413 Excision of malignant lesion up to 1.25 cm
- D7414 Excision of malignant lesion more than 1.25 cm
- D7415 Excision of malignant lesion complicated
- D7440 Excision of malignant lesion up to 1.25 cm
- D7441 Excision of malignant lesion greater than 1.25 cm
- D7460 Removal non-odontogenic cyst/tumor up to 1.25 cm
- D7461 Removal nonodontogenic cyst/tumor greater than 1.25 cm
- D7465 Destruction of lesion(s) by physical or chemical methods
- D7490 Radical resection of maxilla/mandible with bone graft
- D7560 Maxillary sinusotomy for removal of tooth
- D7610 Maxilla - open reduction
- D7620 Maxilla - closed reduction
- D7630 Mandible- open reduction
- D7640 Mandible- closed reduction
- D7650 Malar and/or zygomatic arch - open reduction
- D7660 Malar and/or zygomatic arch - closed reduction
- D7670 Alveolus - closed reduction
- D7671 Alveolus - open reduction
- D7680 Facial bones complicated reduction
- D7710 Maxilla - open reduction
- D7720 Maxilla - closed reduction
- D7730 Mandible - open reduction
- D7740 Mandible - closed reduction
- D7750 Malar and/or zygomatic arch - open
- D7760 Malar and/or zygomatic arch - closed
- D7770 Alveolus - open reduction stabilization of teeth
- D7771 Alveolus - closed reduction stabilization of teeth
- D7780 Facial bones - complicated reduction
- D7810 Open reduction of dislocation
- D7820 Closed reduction of dislocation
- D7830 Manipulation under anesthesia
- D7840 Condylectomy
- D7850 Surgical discectomy, with/without implant
- D7852 Disc repair
- D7854 Synovectomy

- D7856 Myotomy
- D7858 Joint reconstruction
- D7860 Arthrotomy
- D7865 Arthroplasty
- D7870 Arthrocentesis
- D7872 Arthroscopy - diagnosis with/without biopsy
- D7873 Arthroscopy - surgical lavage
- D7874 Arthroscopy - surgical disc reposition
- D7875 Arthroscopy - surgical synovectomy
- D7876 Arthroscopy - surgical discectomy
- D7877 Arthroscopy - surgical debridement
- D7880 Occlusal orthotic device, by report
- D7899 Unspecified temporomandibular joint dysfunctions (TMD) therapy, by report
- D7920 Skin graft
- D7940 Osteoplasty for orthognathic deformities
- D7941 Osteotomy - mandibular rami
- D7943 Osteotomy - ramus, opened with bone graft
- D7944 Osteotomy - segmented or subapical
- D7945 Osteotomy - body of mandible
- D7946 Lefort I - (maxilla -total)
- D7947 Lefort I - (maxilla - segmented)
- D7948 Lefort II/III - osteoplasty of facial bones without graft
- D7949 Lefort II/LLL - with bone graft
- D7950 Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or non autogenous, by report
- D7951 Sinus augmentation
- D7952 Sinus augmentation - vertical approach
- D7955 Repair of maxillofacial soft/hard tissue
- D7980 Sialolithotomy
- D7981 Excision of salivary gland, by report
- D7982 Sialodochoplasty
- D7983 Closure of salivary fistula
- D7990 Emergency tracheotomy
- D7991 Coronoidectomy
- D7995 Synthetic graft
- D7997 Appliance removal including removal of arch bar
- D8210 Removable appliance therapy
- D8220 Fixed or cemented appliance therapy
- D9120 Partial denture sectioning
- D9210 Local anesthesia not in conjunction with operative or surgical procedures
- D9211 Regional block anesthesia
- D9212 Trigeminal division block anesthesia
- D9215 Local anesthesia in conjunction with operative or surgical procedures
- D9219 Evaluation - deep sedation or general anesthesia
- D9223 Deep sedation/general anesthesia – each 15 minute increment
- D9230 Analgesia
- D9243 Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment
- D9248 Non-intravenous conscious sedation (includes non-Iv minimal and moderate sedation)
- D9420 Hospital or ambulatory surgical center
- D9610 Therapeutic drug injection
- D9612 Therapeutic parenteral drugs
- D9910 Application of desentive medication
- D9932 Cleaning and inspection of removable complete denture, maxillary

- D9933 Cleaning and inspection of removable complete denture, mandibular
- D9934 Cleaning and inspection of removable partial denture, maxillary
- D9935 Cleaning and inspection of removable partial denture, mandibular
- D9940 Occlusal guards
- D9942 Repair and/or reline of occlusal guard
- D9943 Occlusal guard adjustment (not eligible within first 6 months after placement of appliance)
- D9999 Unspecified adjunctive procedure, by report
- D5899 Unspecified removable prosthodontic procedure, by report
- D5911 Facial moulage - sectional, by report
- D5912 Facial moulage - complete, by report
- D5913 Nasal prosthesis, by report
- D5914 Auricular prosthesis, by report
- D5915 Orbital prosthesis, by report
- D5916 Ocular prosthesis, by report
- D5919 Facial prosthesis, by report
- D5922 Nasal septal prosthesis, by report
- D5923 Ocular prosthesis, interim, by report
- D5924 Cranial prosthesis, by report
- D5925 Facial augmentation implant prosthesis, by report
- D5926 Nasal prosthesis, replacement, by report
- D5927 Auricular prosthesis, replacement, by report
- D5928 Orbital prosthesis, replacement, by report
- D5929 Facial prosthesis, replacement, by report
- D5931 Obturator prosthesis, surgical, by report
- D5932 Obturator prosthesis, definitive, by report
- D5933 Obturator prosthesis, modification, by report
- D5934 Mandibular resection prosthesis with flange, by report
- D5935 Mandibular resection prosthesis without flange, by report
- D5936 Obturator prosthesis, interim, by report
- D5937 Trismus appliance (not for TMJ), by report
- D5951 Feeding aid, by report
- D5952 Speech aid prosthesis, pediatric, by report
- D5953 Speech aid prosthesis, adult, by report
- D5954 Palatal augmentation prosthesis, by report
- D5955 Palatal lift prosthesis, definitive, by report
- D5958 Palatal lift prosthesis, interim, by report
- D5959 Palatal lift prosthesis, modification, by report
- D5960 Speech aid prosthesis, modification, by report
- D5982 Surgical stent, by report
- D5983 Radiation carrier, by report
- D5984 Radiation shield, by report
- D5985 Radiation cone locator, by report
- D5986 Fluoride gel carrier, by report
- D5987 Commissure splint, by report
- D5988 Surgical splint, by report
- D5991 Topical vesiculobullous disease medicament carrier, by report
- D5992 Adjust maxillofacial prosthetic appliance, by report
- D5993 Maintenance and cleaning of a maxillofacial prosthesis (extra or intraoral) other than required adjustments, by report
- D5999 Unspecified maxillofacial prosthesis, by report

Orthodontic services (covered as **medically necessary**)

- D0470 Diagnostic casts

- D8010 Limited orthodontic treatment of primary dentition
- D8020 Limited orthodontic treatment - transitional dentition
- D8030 Limited orthodontic treatment - adolescent dentition
- D8040 Limited orthodontic treatment - adult dentition
- D8050 Interceptive treatment - primary dentition
- D8060 Interceptive treatment - transitional dentition
- D8070 Comprehensive treatment - transitional dentition
- D8080 Comprehensive treatment - adolescent dentition
- D8090 Comprehensive treatment - adult dentition
- D8660 Pre-orthodontic treatment examination to monitor growth and development
- D8670 Periodic orthodontic treatment visit
- D8680 Orthodontic retention
- D8681 Removable orthodontic retainer adjustment
- D8691 Repair of orthodontic appliance
- D8693 Rebonding or recementing and/or repair, as required, of fixed retainers
- D8694 Repair of fixed retainers, includes reattachment
- D8999 Unspecified orthodontic treatment, by report
- D8692 Replacement of lost or broken retainer (once per arch)

Pediatric Vision Care Benefit Eye Exams, eyeglasses and/or contact lenses Optional lenses and treatments	100% Usual and Reasonable Charge 60% Usual and Reasonable Charge

Pediatric Vision Care benefits are subject to the medical plan's **deductibles** and **maximum out-of-pocket**

- Pediatric comprehensive low vision evaluations performed by a legally qualified ophthalmologist or optometrist - limited to one vision evaluation every five (5) years; 4 follow up visits in any five year period
- Office Visits to ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, prescription lenses, including glass or plastic lenses, all lenses power (single, bifocal, trifocal, lenticular), fashion and gradient tinting, ultraviolet protective coating, oversized and glass grey #3 prescription sunglass lenses – limited to one set per plan year
- Prescription contact lenses (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery), limited as follows:
  - Daily disposables: up to 3 month supply
  - Extended Wear disposable: Up to 6 month supply
  - Non-disposable – Up one set per plan year
- Optical Devices – limited to one optical device per plan year

Limitations: We will cover either prescription lenses for eyeglass frames or prescription contact lenses but not both.

Chiropractic Care Benefit Subject to a maximum number of visits of 20 per Policy Year	80% of the Preferred Allowance Precertification required after the 5th visit	60% of Usual and Reasonable Charge
Bariatric Surgery Benefit	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Acupuncture	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Telemedicine or Telehealth Service	80% of the Preferred Allowance	60% of Usual and Reasonable Charge

Chemotherapy and Radiation Therapy	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of the Preferred Allowance	60% of Usual and Reasonable Charge
Mandated Benefits		
AIDS Vaccine	Same as any other Preventive Service	The Usual and Reasonable Charge stated above
Alzheimer's Disease	Same as any other Covered Sickness	
Breast Cancer Screening	Same as any other Preventive Service	
Cancer Screening	Same as any other Preventive Service	
Cervical Cancer Screening Benefit	Same as any other Preventive Service	
Clinical Trials Benefit	Same as any other Covered Sickness	
Contraceptive Methods	Same as any other Covered Sickness, unless considered a Preventive Service	
Dental Anesthesia	Same as any other Covered Sickness	
Diabetes Benefit	Same as any other Covered Sickness	
Diethylstilbestrol Coverage	Same as any other Covered Sickness	
HIV Testing	Same as any other Covered Sickness	
Mammography	Same as any other Preventive Service	
Mastectomy Benefit	Same as any other Covered Sickness	
Organ Donation Services	Same as any other Covered Sickness	
Organ Transplant	Same as any other Covered Sickness	
Osteoporosis	Same as any other Covered Sickness	
Pain Management Medication for Terminally Ill	Same as any other Prescription Drug	
Pediatric Asthma Services	Same as any other Covered Sickness	
Pediatric Preventive Services	100% of the Preferred Allowance	60% of Usual and Reasonable Charge
Phenylketonuria Testing and Treatment Benefit	Same as any other Covered Sickness	
California Prenatal Screening Program	No cost sharing	
Prostate Cancer Screening	Same as any other Preventive Service	
Reconstructive Surgery	Same as any other Covered Sickness	
Special Shoe Benefit	Same as any other Covered Sickness	

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum for Double Dismemberment or Loss of Life $5,000

Loss must occur with 180 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one loss occurs as the result of any one Accident. This benefit is payable in addition to any other benefits payable under the Policy.

Medical Evacuation Expense

The maximum benefit for Medical Evacuation is shown in the Schedule of Benefits.

If:
a. You are unable to continue Your academic program as the result of a Covered Injury or Covered Sickness;
b. That occurs while you are covered under the Certificate,

We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:
a. You must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five or more consecutive days immediately prior to medical evacuation;
b. Prior to the medical evacuation occurring, the attending Physician must have recommended, and We must have approved the medical evacuation;
c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;
d. No benefits are payable for Usual and Reasonable Expenses after the date Your insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination;
e. Evacuation to Your Home Country terminates any further insurance under the Certificate for You; and
f. Transportation must be by the most direct and economical route.

Repatriation Expense

The maximum benefit for Medical Evacuation is shown in the Schedule of Benefits.

If You die while covered under the Certificate, We will pay a benefit. The benefit will be the necessary Usual and Reasonable charges for preparation, including cremation, and transportation of the remains to Your place of residence in Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Exclusions and Limitations

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state imposed requirements will be administered to comply with the requirements of the federal or state guideline, whichever is more favorable to You.

The Certificate does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the Certificate and as shown in the Schedule of Benefits.

1. **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. by the person's attending physician or dentist.
3. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
4. professional services rendered by an Immediate Family Member or anyone who lives with You.
5. weak, strained or flat feet, corns, calluses ingrown toenails except for Treatment because of Injury, infection or disease.
6. diagnostic or surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
7. expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.

9. any expenses in excess of Usual and Reasonable charges except as provided in the Certificate.
10. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which You are required to pay.
11. services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
12. expenses incurred after:
    - The date insurance terminates as to the Insured Person, except as specified in the extension of benefits provision; and
    - The end of the Policy Year specified in the Benefit Schedule.
13. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Certificate.
14. charges incurred for heat Treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
15. Weight management. Weight reduction. Nutrition programs. Treatment for obesity except surgery for morbid obesity (bariatric surgery). Surgery for removal of excess skin or fat. this does not apply to nutritional counseling or any screening or assessment specifically provided under the Preventive Care Services benefit, or otherwise specifically covered under the Certificate.
16. charges for hair growth or removal unless otherwise specifically covered under the Certificate.
17. expenses for radial keratotomy except as required for repair caused by a Covered Injury or duplicate spare eyeglasses or lenses or frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes or unless otherwise covered under the Pediatric Vision Care Benefit.
18. charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
19. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical Treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    - For the purposes of this provision, Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    - For the purposes of this provision, Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance or alter their personal concept of body image. In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be covered unless such care and services are performed solely and directly as a result of a Medically Necessary mastectomy.
20. Treatment to the teeth, including orthodontic braces and orthodontic appliances, or unless otherwise covered under the Pediatric Dental Care Benefit including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
21. You are:
    - committing or attempting to commit a felony, or
    - being engaged in an illegal occupation.
22. braces and appliances, except as specifically provided in the Schedule of Benefits.
23. Custodial Care service and supplies.
24. charges for hot or cold packs.
25. expenses that are not recommended and approved by a Physician.
26. routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
27. Sleep Disorders screening including testing, unless medically necessary.
28. Under the Prescription Drug Benefit shown in the Schedule of Benefits, any drug or medicine:
    - which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided in the Prescription Drug Benefit section of this plan;
    - for the purpose of weight control;
    - fertility drugs;
    - vitamins, minerals, unless prescribed for preventive purposes under ACA;
    - food supplements, unless prescribed for the treatment of PKU;
    - sexual enhancements drugs;
    - dietary supplements;

- cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, except as specifically provided in the Certificate;
- blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) prescription order per Policy Year;
- refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
- drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- purchased after coverage under the Certificate terminates;
- consumed or administered at the place where it is dispensed;
- if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason; o

29. non-chemical addictions.
30. non-physical, occupational, speech therapies (art, dance, etc.).
31. modifications made to dwellings.
32. general fitness, exercise programs.
33. hypnosis.
34. rolfing.
35. biofeedback.
36. hyperhidrosis.

Third Party Refund

When:

1. You are injured through the negligent act or omission of another person (the "third party"); and
2. benefits are paid under the Certificate as a result of that Injury,

We are entitled to a refund by You of all Certificate benefits paid as a result of the Injury.

The refund must be made to the extent that You receive payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. You must complete and return the required forms to Us upon request.

If You engaged an attorney, then the lien may not exceed the lesser of the following amounts:

1. The maximum amount determined pursuant to the rule above (for noncapitated payments).
2. One-third of the moneys due to You under any final judgment, compromise, or settlement agreement.

If You did not engage an attorney, then the lien may not exceed the lesser of the following amounts:

1. The maximum amount determined pursuant to the rule above (for non-capitated payments).
2. One-half of the moneys due to You under any final judgment, compromise, or settlement agreement.

Coordination of Benefits

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

Right of Recovery

If the amount of payments made by Our Agent or Us is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Claim Procedures

In the event of either an Injury or a Sickness:

1. Report to a Physician, Hospital or the School's Student Health Services.
2. Written notice of a claim must be given to Us within 20 days after the date of occurrence or commencement of any loss covered by the Certificate, or as soon thereafter as is reasonably possible.
3. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.

CIGNA
PO Box 188061
Chattanooga, TN 37422 – 8061
Electronic Payor ID: 62308

Claim Appeal Process

A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. You do not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, You or Your authorized representative may:

a. review all documents related to the claim and submit written comments and issues related to the denial; and
b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

We will provide You with the contact person who is coordinating the first level review within 3 days of the date of receipt of the grievance.

Please submit all **Claim Appeal** requests to Consolidated Health Plans.

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, Massachusetts 01104
(877) 657-5030
www.chpstudenthealth.com

The Student Health Insurance Plan is underwritten by:
Commercial Casualty Insurance Company
Fort Wayne, IN

As Policy form: CA SHIP CERT (2018)

For a copy of the Company's privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa
(Please indicate the school you attend with your written request)
or
Request one from the Health Office at your School

Representations of the Plan must be approved by the Company.

This is not the Certificate. Rather, it is a brief description of the benefits and other provisions of the Certificate. The Certificate is governed by the laws and regulations of the state in which it is issued and is subject to any necessary State approvals. Any provisions of the Certificate, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state's laws, including those relating to mandated benefits.

Value Added Services

The following are not affiliated with Commercial Casualty Insurance Company and the services are not part of the Plan Underwritten by Commercial Casualty Insurance Company. These value-added options are provided by Consolidated Health Plans.

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:
www.chpstudenthealth.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at (877) 657-5030. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: (877) 305-1966 *or* if you are in a foreign country, call collect at: (715) 295-9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

24 HOUR NURSELINE

Students who enroll and maintain medical coverage in this insurance plan have access to the *24 Hour Nurseline*. This *24-Hour Nurseline* program provides:

- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. The *Nurseline* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *24 Hour Nurseline* toll free number will be on the ID card.

(800) 634-7629

Cigna.

Your out-of-pocket costs may be lower when you utilize Cigna PPO Providers. For a listing of Cigna PPO Providers, go to www.cigna.com or contact Consolidated Health Plans toll-free at (877) 657-5030, or www.chpstudenthealth.com for assistance.

CareConnect
Integrated Behavioral Health from CHP Student Health

With CareConnect from CHP Student Health, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, (**888) 857-5462**, or via the CHP Student Health mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.