AMERICAN UNIVERSITY
WASHINGTON, DC

Student Health Insurance Plan Brochure

2011 / 2012

Offered by:
GM-Southwest, Inc.

Administered by:
GM-Southwest, Inc.

Issued by:
Pan-American Life Insurance Company

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For students who are insured under the Student Health Insurance Plan, a referral is required from the AU Student Health Center prior to receiving treatment outside the Student Health Center.

Please note: When you accept the AU Student Health Insurance Plan, you are accepting the terms and policies of the Plan. Please read this brochure carefully.

This student Health Insurance Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the Customer Service number on your ID card.

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The American University Student Health Insurance Plan

The American University (AU) Student Health Insurance Plan has been developed especially for AU students. The plan provides coverage for accidents and sicknesses that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. American University is pleased to offer the plan as described in this brochure. Please keep this brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policies. If any discrepancy exists between this brochure and the Policies, the Master Policies will govern and control the payment of benefits.

Definitions

Accident
An occurrence which (a) is unforeseen, (b) is not due to or contributed to by sickness or disease of any kind, and (c) causes Injury.

Actual Charge
The Actual Charge made for a covered service by the provider that furnishes it.

Aggregate Maximum
The maximum benefit that will be paid under the policies for all covered medical expenses incurred by an insured person for the academic year.

Brand-Name Prescription Drug or Medicine
A prescription drug, which is protected by trademark registration.

Coinsurance
The percentage of covered medical expenses payable by GM-Southwest, Inc. under the Student Health Insurance Plan.

Copay
The amount that must be paid by the insured person at the time services are rendered by a Preferred Provider. Copay amounts are the responsibility of the insured person.

Covered Medical Expenses
Those charges for any treatment, service, or supplies covered by the policies which are: (a) not in excess of the reasonable charges, or (b) not in excess of the charges that would have been made in the absence of this coverage, and (c) incurred while the policy is in force as to the covered person except with respect to any expenses payable under the Extension of Benefits provision.

Insured person
A covered student or dependent whose coverage is in effect under the policy. See the Eligibility sections of this brochure for additional information.

Creditable Coverage
Creditable Coverage means a person's prior medical coverage as defined in the Federal Health Insurance Portability and Accountability Act (HIPAA) of 1996. Such coverage includes the following: coverage issued on a group or individual basis, Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefits risk pool, the Federal Employees' Health Benefit Plan (FEHBP), a public health plan as defined in the regulations, and any health benefit plan under Section 5(e) of the Peace Corps Act.

Deductible
A specific amount of covered medical expenses that must be incurred and paid for by the insured person before benefits are payable under the Plan. Deductible amounts are the responsibility of the insured person.

Elective Treatment
Medical treatment that is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Covered Person's effective date of coverage. Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; sexual reassignment surgery; sub mucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; immunization; vaccines; treatment of infertility; and routine physical examinations.

Emergency Medical Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:
• Placing the person's health in serious jeopardy; or
• Serious impairment to bodily function; or
• Serious dysfunction of a body part or organ; or
• In the case of a pregnant woman, serious jeopardy to the health of the fetus.
It does include an accident or serious illness such as heart attack, stroke, poisoning, loss of consciousness or respiration, and convulsions. It does not include elective care, routine care, or care for non-emergency illness.

Injury
Bodily injury caused by an accident; this includes related conditions and recurrent symptoms of such injury.

Medically Necessary
A service or supply that is necessary, and appropriate, for the diagnosis or treatment of a Sickness, including a clinically significant mental illness, or injury, based on generally accepted current medical practice.
In order for a treatment, service, or supply to be considered medically necessary, the service or supply must:

- Be care or treatment which is likely to produce a significant positive outcome as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative outcome than any alternative service or supply, both as to the sickness or injury involved and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person. It must be as likely to result in information that could affect the course of treatment as any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition. It must be no more likely to produce a negative out come than any alternative service or supply, both as to the Sickness or Injury involved and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply) than any alternative service or supply to meet the above tests. In determining if a service or supply is appropriate under the circumstances, GM-Southwest, Inc. will take into consideration:
- Information relating to the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to GM-Southwest, Inc.'s attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, a mental health, or a dental professional; or
- Those furnished mainly for the personal comfort, or convenience, of the person, any person who cares for him or her, or any person who is part of his or her family, any healthcare provider, or healthcare facility; or
- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely and adequately be diagnosed or treated while not confined; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or another less costly setting.

Negotiated Charge
The maximum charge a preferred care provider has agreed to make as to any service or supply for the purpose of the benefits under the Student Health Insurance Plan.

In-Network Care
A health care service or supply furnished by a health care provider that is not a participating provider if, as determined by GM-Southwest, Inc. (a) the service or supply could have been provided by a participating provider and (b) the provider is of a type that falls into one or more of the categories of providers listed in the directory.

Out-of-Network Provider (or Non-Participating Provider)
A health care provider that has not contracted to furnish services or supplies at a negotiated charge.

Out-of-Network Pharmacy
A pharmacy not party to a contract with GM-Southwest, Inc. or a pharmacy that is party to such a contract but which does not dispense prescription drugs in accordance with its terms.

Out-of-Pocket Limit
The amount that must be paid, by the covered student, or the covered student and their covered dependents, before covered medical expenses will be payable at 100%, for the remainder of the academic year.
The following expenses do not apply toward meeting the Out-of-Pocket Limit:

- Copays;
- Expenses that are not Covered Medical Expenses;
- Penalties;
- Expenses for Prescription Drugs; and
- Other expenses not covered by this Policies.

Pharmacy
An establishment where prescription drugs are legally dispensed.

Physician
A legally qualified physician licensed by the state in which they practice, and any other practitioner who must by law be recognized as a doctor legally qualified to render treatment, including nurse practitioners and physician's assistants.

In-Network Provider
A health care provider that has contracted to furnish services or supplies for a negotiated charge, but only if the provider is a participating provider for the service or supply involved, and the class of which the insured person is a member.
Participating Pharmacy: A pharmacy which is a participating pharmacy and is contracted to dispense drugs to persons covered under the policies, but only while the contract remains in effect and when the pharmacy dispenses a prescription drug under the terms of its contract.

Prescription
An order of a prescriber for a prescription drug. If it is an oral order, it must be promptly put in writing by the pharmacy.

Reasonable Charge
Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- The provider's usual charge for furnishing it; and
- The charge GM-Southwest, Inc. determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- The charge GM-Southwest, Inc., Inc. determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In some circumstances, GM-Southwest, Inc. may have an agreement, either directly or indirectly through a third party, with a provider which sets the rate that GM-Southwest, Inc. will pay for a service or supply. In these instances, in spite of the methodology described above, the Reasonable Charge is the rate established in such agreement.
In determining the reasonable charge for a service or supply that is:

- Unusual; or
- Not often provided in the area; or
- Provided by only a small number of providers in the area,

GM-Southwest, Inc. may take into account factors, such as:

- The complexity;
- The degree of skill needed;
- The type of specialty of the provider;
- The range of services or supplies provided by a facility; and
- The prevailing charge in other areas.

Sickness
A disease or illness including related conditions and recurrent symptoms of the sickness. A sickness also includes pregnancy and complications of pregnancy.

Where To Find Help

Got Questions?
Get Answers with the website that GM-Southwest, Inc. has designed for its American University Health Insurance customers at www.myaustudentinsurance.com. You may also contact the customer service department of GM-Southwest, Inc. at (877) 885-3298.

As a GM-Southwest, Inc. Student Health Insurance Plan member, you have access to a secure member website, packed with personalized benefits and health information. You can take full advantage of our interactive website to complete a variety of self-service transactions online.

By logging into www.myaustudentinsurance.com, you can:

- Review who is covered under your Student Health Insurance Plan.
- Request member ID cards.
- View Claim Explanation of Benefits (EOB) statements.
- Find health care professionals and facilities that participate in your Student Health Insurance Plan.
- Send an e-mail to GM-Southwest, Inc. Customer Service at your convenience.
- Utilize our "Live Chat" option to chat online with a customer service representative.
- Print a temporary ID card.

How do I register?

- Go to www.myaustudentinsurance.com.
- Click on "Register."
- Follow the online instructions to register your personal information.
- Select a username and password that you will not forget.
- Once registered, click "Login" and enter your username and password.

Your registration is now complete, and you can begin accessing your personalized information!

Need help with registering onto the American University website?
Contact our customer service department at 877-885-3298 or use the "Live Chat" option on your website at www.myaustudentinsurance.com.

For Questions About:

- Insurance Benefits
- Enrollment
- Claims Processing
- Davis Vision
- CareFirst Blue Choice Dental HMO
- WellDyneRx Prescription Benefits

Please contact:
GM-Southwest, Inc.
P.O. Box 6000
Frisco, TX 75034
(877) 885-3298

For Questions About ID Cards:
If you select the American University Student Health Insurance Plan, you will be mailed a permanent ID card to your in-session address listed on the university system. This card is for identification only. It is not a guarantee of eligibility or benefits. The card becomes active on the date of enrollment or eligibility under the Student Health Insurance Plan. While you do not need an ID card to be eligible to receive benefits, students are encouraged to carry their insurance card with them at all times.
For lost ID cards, contact: GM-Southwest, Inc. at (877) 885-3298 or you may visit www.myaustudentinsurance.com to replace your identification card.

For Questions About:

- Waiver Process
- Referrals

Please contact:
American University Student Health Center
(202) 885-3380
www.american.edu/healthcenter

For Questions About:

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

Please contact:
WellDyneRx
1-888-479-2000

For Provider Listings (Including a listing of Participating Pharmacies):
You can use the Student Health Insurance Plan's website at www.myaustudentinsurance.com.

Worldwide Web Access:

- American University Student Health Center: www.american.edu/healthcenter
- American University Counseling Center: www.american.edu/counseling
- GM-Southwest, Inc.: www.myaustudentinsurance.com.

American University Student Health Center (SHC)

Your health care needs are best met when an organized system of health care providers at the American University Student Health Center manages the treatment. If you are enrolled in the Student Health Insurance Plan, you must attempt to use the AU Student Health Center first to maximize your student health benefits. Failure to utilize the Student Health Center will result in coverage of benefits being declined. See the Description of Benefits section in this brochure.
Please refer to this brochure for additional information regarding the SHC referral requirement under the Student Health Insurance Plan.

American University Student Health Insurance Plan

This is a brief description of the medical expense benefits available for AU students and their eligible dependents. The Student Health Insurance Plan is underwritten by Pan-American Life Insurance Company. The exact provisions governing this insurance are contained in the Master Policies issued to American University. Please contact GM-Southwest, Inc. at (877) 885-3298 during normal business hours to receive a copy of the Master Policies.

Policy Periods

1. **Fall Semester Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:00 a.m. on August 21, 2011, and will terminate at 11:59 p.m. on December 31, 2011. Students and dependents enrolling after August 31, 2011 will become effective upon receipt of the completed Application and payment to GM-Southwest, Inc.
2. **Spring/Summer Semester students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:00 a.m. on January 1, 2012, and will terminate at 11:59 pm. on August 20, 2012. Students and dependents enrolling after January 31, 2012 will become effective upon receipt of the completed Application and payment to GM-Southwest, Inc.
Coverage for new summer semester students will become effective at 12:01 a.m. on May 11, 2012, and will terminate at 11:59 pm . on August 20, 2012. Later effective dates may apply if you enroll for a later Summer Session.
3. **Full-time students:** For degree-seeking students whose status is considered full time because they have submitted "In Lieu of Credit Hours" documentation, coverage will become effective no earlier than August 21, 2011 (January 1, 2012 for Spring/Summer Semester) upon receipt of the completed application and payment to GM-Southwest, Inc.
4. **Part-time students:** Coverage will become effective no earlier than August 21, 2011 (January 1, 2012 for Spring/Summer Semester) upon receipt of the completed Application and payment to GM-Southwest, Inc.
5. **Insured dependents:** Coverage will become effective upon receipt of the completed Application and payment to GM-Southwest, Inc. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policies. Examples include, but are not limited to, the date the student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

Premium Rates

	Academic Year* 8/21/11 – 8/20/12	Fall Semester Only 8/21/11 – 12/31/11	Spring/ Summer Semester 1/1/12 – 8/20/12	Summer Semester 5/11/12 – 8/20/12
Student	$1,720	$675	$1,095	$474
Spouse/Domestic Partner	$6,925	---	$4,400	$1,880
Each Child	$4,020	---	$2,865	$1,090

* Academic Year provides coverage for Fall and Spring/Summer

Student Coverage

Eligibility

All full-time degree-seeking, residential, and international students with F1 and J1 Visas enrolled at American University are required to carry health insurance coverage. All students taking six or more credit hours are eligible to enroll in the Student Health Insurance Plan. Students whose status is considered full time because they have submitted "In Lieu of Credit Hours" documentation are also eligible for the Student Health Insurance Plan, but must enroll voluntarily at www.myaustudentinsurance.com. Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased in order to remain eligibile. Independent study, Internet classes and television (TV) courses may not fulfill the eligibility requirements that the covered student actively attends classes. If the eligibility requirements are not met, The Company's only obligation is to refund the premium.

Students who are graduating in December 2011 are also covered through August 20, 2012 but may wish to discontinue participation in the AU plan upon graduation. In this situation, a pro-rata refund of the premium may be made. Graduates who wish to discontinue coverage must send an email to insurance@american.edu before December 31st. Once it has been verified that you have graduated, a pro rated refund will be applied to your student account. Your insurance will expire on December 31, 2011.

Students who reduce their course load during the semester and are no longer full time may have the health insurance fee removed from their student account and be removed from the Student Health Insurance Plan. These students will have to voluntarily enroll in order to keep their benefits. Please contact the Student Health Center for more information.

Waiver Process/Procedure

STUDENTS WHO WISH TO WAIVE OUT OF THE PLAN MUST DO SO BY AUGUST 1, 2011

Eligible students will be enrolled in the Student Health Insurance Plan and billed automatically by the University unless a valid Waiver has been received by American University by the identified deadline dates. Students can waive participation in the AU Student Health Insurance Plan and avoid automatic billing by completing the Student Health Insurance Waiver Form. Please visit the Student Health Center website at www.american.edu/healthcenter for instructions on waiving participation in the the Student Health Insurance Plan. Students who do not respond by the deadline dates previously listed will be automatically enrolled in the Student Health Insurance Plan.

Premium Refund Policy

Except for medical withdrawal due to a covered accident or sickness, any student withdrawing from school during the first 31 days of the period for which coverage is purchased shall not be covered under the Policies and a full refund of the premium will be made unless a claim has been filed. Students withdrawing after 31 days will remain covered under the policy for the full period for which the premium has been paid. No refund will be allowed.

An insured person entering the armed forces of any country will not be covered under the policies as of the date of such entry. A pro-rata refund of premium will be made for such person, and any covered dependents, upon written request received by GM-Southwest, Inc. within 90 days of withdrawal from school.

Dependent Coverage

Eligibility

Eligible students who enroll may also insure their eligible dependents. Eligible dependents are the spouse, including domestic partners, and unmarried children under 19 years or through the age of 25 if they are full-time students at an accredited school.

Dependent and domestic partner eligibility expires concurrently with that of the insured student. See "Domestic Partners" section below for further details.

Domestic Partners
The student and domestic partner (same sex) must sign an affidavit of domestic partnership attesting to meeting certain criteria before the domestic partner is eligible for coverage under the Student Health Insurance Plan. Affidavits, as well as a description of eligibility criteria, are available by contacting the AU Student Health Center.

Enrollment
To enroll the dependent(s) of a covered student, please complete the online Enrollment Form, available at www.myaustudentinsurance.com. If the enrollment application is received before September 1, 2011 there will be no break in coverage. To obtain an Enrollment Form go to www.myaustudentinsurance.com.

Newborn Infant Coverage and Adopted Child Coverage

A child born to an insured person shall be covered for accident, sickness, and congenital defects for 31 days from the date of birth. At the end of this 31-day period, coverage will cease under the 2011-2012 American University Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the insured person must (1) enroll the child within 31 days of birth and (2) pay the appropriate premium.
Coverage is provided for a child legally placed for adoption with an insured person for 31 days from the moment of placement, provided the child lives in the household of the insured person and is dependent upon the insured person for support. To extend coverage for an adopted child past the 31 days, the insured person must (1) enroll the child within 31 days of placement of such child and (2) pay the appropriate premium.

CareFirst® BlueCross® Blueshield® Preferred Network

GM-Southwest, Inc. has arranged for you to access the CareFirst® BlueCross® Blueshield® Preferred Network in your local campus community. Using our Participating Provider Network you may access in-network savings for services rendered nationally if you require treatment or hospitalization outside the immediate area of the American University campus.

To maximize your savings and reduce your out-of-pocket expenses, select a provider that is participating either in the CareFirst® BlueCross® Blueshield® Preferred Network. GM-Southwest, Inc. also has access to nationwide provider networks when treatment is rendered outside the CareFirst BlueCross BlueShield Preferred Network. It is to your advantage to utilize an In-Network Provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. In-Network providers are independent contractors and are neither employees nor agents of American University, GM-Southwest, Inc. or Pan-American Life Insurance Company. You can obtain information regarding In-Network providers by accessing www.myaustudentinsurance.com. You can use our website to find out whether a specific provider is In-Network or to find a list of In-Network providers practicing in your area. You may also contact GM-Southwest, Inc. at (877) 885-3298.

Some preferred provider facilities in your local area are: Sibley Memorial Hospital, Suburban Hospital, Children's National Medical Center, George Washington University Hospital, Georgetown University Hospital, Howard University Hospital, and Washington Hospital Center.

Note: The above is not an all-inclusive list. You can obtain information regarding other In-Network providers through the internet at www.myaustudentinsurance.com.

Care First BlueCross Blue Shield is the business name of CareFirst of Maryland, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association.
® Registered trademark of CareFirst of Maryland, Inc.

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent license of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

Referral Requirements:

Medical *(A Student Health Center Referral is Required for any medical condition)*
Students' health care needs can best be satisfied when an organized system of health care providers at American University Student Health Center (SHC) manages the treatment. Students are encouraged to choose an SHC provider to be his or her primary care provider (PCP). Each student's care is managed through his or her chosen PCP at the SHC. The student's chosen provider can provide referrals to specialty services when required. Students must first come to the SHC for an assessment of their medical condition and possible treatment. You will only be given a referral for treatment outside the SHC if you require care that the SHC is not able to provide. Referrals are only good for sixty (60) days from the date they are issued. If an insured person still needs to receive treatment after sixty days, the insured person must return to the Student Health Center for an updated referral. ***Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage and will not be paid.***

Referral Process/Health Ticket
What is the Health Ticket and how does it work?

To maximize benefits students must obtain a referral from the AU Student Health Center and be referred to a CareFirst® BlueCross® Blueshield® Preferred Network. The Student Health Center utilizes a Health Ticket as an Online Referral. The Student Health Center will enter a Health Ticket for each referral that will be provided to a participating provider. GM-Southwest, Inc. will also receive a copy of the referral so that claims will be processed accordingly.

The Health Ticket works similar to an airline e-ticket and is easy to obtain. Students can print their Health Ticket by going to www.myaustudentinsurance.com. Click on the "Health Ticket" link. Students simply input their identification number and date of birth.

The Health Ticket provides benefit information such as deductibles and copays. The Health Ticket also indicates whether the doctor or hospital selected is an in or out-of-network provider.

A SHC referral for outside medical care is not necessary only under the following conditions:

1. The enrollee is a dependent. (Dependents are not eligible to use the SHC and therefore are exempt from the above limitations and requirements.)
2. The enrollee is ineligible to use the SHC (i.e., has graduated from AU or is in optional practical training).
3. It is for treatment of an Emergency Medical Condition. For any follow-up care you must return to the SHC and obtain a referral.
4. When the SHC is closed; enrollees can obtain care recommendations from the following source: Managed Care Concepts Nurse Line at (866) 751-2723 (24 hours a day).
5. The enrollee's and the provider's addresses at the time of service are more than 25 miles away from campus.
6. Treatment for Mental Health Services.

Important: For continuing enrollees, a new referral must be issued each Academic Year for any condition covered under the prior year's Policy that will be covered under this year's Policies. Student Health Center consults expire after 60 days. You must return to the SHC for a new referral every 60 days.
No referral is required to access mental health providers. However, students needing assistance in determining their need for mental health services or in locating mental health providers in the community can consult with staff at the Counseling Center or Student Health Center.

Prescription Drugs

The Student Health Insurance Plan offers a prescription drug card through WellDyneRx that is tailored to the prescription drug needs of the American University student. WellDyneRx is a nationwide prescription drug card service. The prescription drug card allows the insured individual immediate access to prescription coverage. Each insured student receives a GM-Southwest, Inc. Identification Card with a WellDyneRx logo, allowing access to thousands of participating pharmacies throughout the United States. Your identification card will include your WellDyneRx identification number and group number. Simply present your ID card at a participating pharmacy to obtain your prescription drugs. The individual is responsible for a $10 Copay for generic prescription drugs, a $25 Copay for Formulary Brand prescription drugs and a $45 Copay for Non-Formulary Brand prescription drugs up to a maximum of $4,000 per academic year. Medications excluded from this benefit include, but are not limited to; allergy sera, allergy medications, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.

Mail-Order Drug Program Expenses

Mail order is available with pre-authorization and your health plan has partnered with WellDyneRx to provide you with mail order pharmacy services.

Covered Medical Expenses for a 90-day supply of drugs ordered through WellDyneRx mail order program are covered at 100% after a $25 copay for Generic prescription drugs, $65 for Formulary Brand prescription drugs and $115 for Non-Formulary Brand prescription drugs. To obtain pre-authorization for a mail order prescription, please call our customer service department at 877-885-3298.

Covered Medical Expenses for Drugs are payable up to a maximum of $4,000 per Academic Year.

WellDyneRx mail order pharmacy provides you with a convenient, cost and time-saving option to obtain your long-term and maintenance medications which include, but are not limited to:

- High Blood Pressure medication
- Arthritis medication
- Allergy medication
- Diabetes medication
- Asthma medication
- Cholesterol medication

To realize your cost and maximize the benefits of mail order service, use WellDyneRx mail order pharmacy to fill your prescriptions for long-term and maintenance medications.

When you take advantage of mail order pharmacy services, you are sent up to a three-month supply and at a copay that may save you money over your retail benefit.

Easy-to-Use Online Features at: myWDRx.com

WellDyneRx provides you with an interactive website where you can quickly access information and request services.

- Enroll online
- Review mail order pharmacy services
- Order prescription refills
- Track your orders
- Manage your profile, including shipping address and credit cards
- View history of mail order claims
- Compare brand and generic drugs
- Download mail order forms
- View drug-specific information and health information
- Ask a pharmacist questions
- Research disease information
- Browse frequently asked questions
- Review the comprehensive glossary
- Stay informed with news from the pharmacy

Questions
If you would like to learn more about mail order or would like to enroll to use mail order, please feel free to call Member Services at: 888-479-2000. Monday through Friday 7 am to 7 pm MST; Saturday 8:00 am to 12 pm MST.
Diabetic Testing Supplies Expense
Benefits include charges for testing material used to detect the presence of sugar in the person's urine or blood for monitoring glycemic control.
Diabetic Testing Supplies are limited to:
- Lancet devices,
- glucose monitors, and
- test strips.

Syringes, or other items used in the treatment of diabetes are not covered by this benefit.
Payable as any Sickness.

After-Hours Care

(Please note that the Program described below is neither underwritten nor administered by GM-Southwest, Inc.)
Any student who lives in a University Residence Hall and experiences an emergency when the SHC is closed should notify Public Safety or the Resident Assistant on duty. American University staff will contact appropriate DC emergency medical services. Students who are not experiencing an emergency should first contact Managed Care Concepts Nurse Line at (866) 751-2723. This Nurse Hotline will connect the caller to a registered nurse who will assess the student's condition and refer him or her to the appropriate level of care. Students who are referred to an Emergency Room should contact Public Safety for a taxi voucher. Public Safety can provide taxi vouchers to Sibley Hospital. The Sibley Hospital Emergency Room will provide the student with a voucher for their return trip to American University. Students may choose to go to any participating hospital.
Students who live off campus or who are traveling in the continental United States may also use the Managed Care Concepts Nurse Line. For emergencies that occur off campus, however, students should call 911 or contact emergency assistance in the local area.

Pre-Certification Requirements:

This program is designed to help you receive quality, cost-effective medical care. Services requiring Pre-Certification include: inpatient admissions, outpatient surgeries, rehabilitative physical therapy, occupational therapy, speech and language therapy, CAT Scans and MRIs.

If you do not secure Pre-Certification for the above mentioned services, your covered medical expenses will be subject to a $200 per incident penalty. Pre-certification is designed to help you receive quality, cost-effective medical care.
- All above services must be certified in advance by contacting Managed Care Concepts at (866) 750-2723.
- Pre-certification does not guarantee the payment of benefits. Each claim is subject to medical policy review in accordance with the exclusions and limitations contained in the Policies, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the Student Health Insurance Plan.
- If you do not secure Pre-certification for non-emergency inpatient admissions or provide notification for emergency admissions, your covered medical expenses will be subject to a $200 per admission deductible.

Pre-Certification of Non-Emergency Inpatient Admissions

The patient, physician, or hospital must telephone at least three business days prior to the planned admission.

Notification of Emergency Admissions
The patient, patient's representative, physician, or hospital must telephone Managed Care Concepts at (866)750-2723

within one business day following admission.

Description of Benefits

Payment will be made as allocated herein for covered medical expenses incurred for any one accident or any one sickness while insured under the Student Health Insurance Plan, not to exceed an aggregate maximum while continuously insured of $250,000 for any one covered accident or any one covered sickness per academic year.

In addition to the plan's aggregate maximum the policies may contain benefit level maximums. Please review the summary of benefits section of this brochure for any additional benefit level maximums.

The payment of any copays, deductibles, the balance above any coinsurance amount, and any medical expenses not covered are the responsibility of the insured person.

To maximize your savings and reduce out-of-pocket expenses, select a participating provider (In-Network). It is to your advantage to utilize an In-Network provider because significant savings can be achieved from the substantially lower rates these providers have agreed to accept as payment for their services. Out-of-Network care is subject to reasonable charge allowance maximums. Any charges in excess of the reasonable charge allowance are not covered under the Student Health Insurance Plan.

To obtain a listing of In-Network providers, please visit www.myaustudentinsurance.com. You can find out whether a specific provider is In-Network or to find a listing of In-Network providers practicing in your area. You can also contact the GM-Southwest, Inc. Customer Service Department at (877) 885-3298.

Summary of Benefits Chart

The following benefits are subject to the imposition of Policies limits and exclusions. All coverage is based on reasonable charges unless otherwise specified.

This Plan always pays benefits in accordance with any applicable District of Columbia Insurance Law(s).

Plan Maximum Deductible (per Person)

$250,000 per Injury or Sickness per Academic Year.

In-Network Care: $150 per Academic Year.

Out-of-Network Care: $200 per Academic Year.

The Deductible is waived under the following circumstances:

1. Laboratory expenses for services that are ordered by a SHC provider during a SHC visit.
2. Emergency room services (facility and Physician charges).
3. Routine Pap smears and mammograms.
4. Covered Prescription contraceptive devices.
5. Routine Prostate Specific Antigen (PSA) tests.

Out-of-Pocket Maximum (includes Deductibles)

Preferred Care and Non-Preferred Care: $4,000 per insured per Academic Year.

Maximum Out-of-Pocket Expense (includes the Deductibles)

The maximum dollar amount an insured is required to pay out during a academic year (subject to the limitations listed below):

Once an insured individual has reached the applicable out-of-pocket maximum (as stated above) within a Academic Year for Covered Medical Expenses, the Plan will pay 100% up to the overall plan maximum.

Any applicable In-Network Copays, Out-of-Network Deductibles, Prescription Drug Expenses, or expenses in excess of the Reasonable Charge do not apply towards meeting the out-of-pocket maximum. Any amount payable as a result of failure to secure Pre-certification for inpatient admissions also does not apply towards meeting the out-of-pocket maximum. Charges in excess of any specified maximum and non-covered services are not applied toward meeting the out-of-

pocket maximum and are the responsibility of the insured.
Inpatient Services Benefits (Please refer to Inpatient Admission Pre-Certification Requirements)

Inpatient Hospitalization Expenses
Covered Medical Expenses are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Intensive Care Unit Expenses
Covered Medical Expenses are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Physician's Hospital Visit Expenses
Covered Medical Expenses are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Surgical Benefits (Inpatient and Outpatient)

Surgical Expenses
Covered Medical Expenses for charges for surgical services performed by a Physician are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Assistant Surgical Expenses
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Anesthetist Expenses
Covered Medical Expenses for the charges of an anesthetist during a surgical procedure for surgical services performed during a surgical operation are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Outpatient Benefits
Covered Medical Expenses include, but are not limited to, Physician's office visits, hospital or outpatient department or emergency room visits, chemotherapy, radiation therapy, tests and procedures, clinical lab, or radiological facility or other similar facility licensed by the state.

Physician's Office Expenses
Covered Medical Expenses for the diagnosis and treatment of a Sickness Visit are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Pre-Admission Testing Expenses
Covered Medical Expenses are payable as follows:
In-Network Care: 80% of the Negotiated Charge.

Out-of-Network Care: 60% of the Reasonable Charge.
Physiotherapy Expenses (Requires an AU Health Center referral and Pre-Certification through Managed Care Concepts. Limited to services provided in lieu of surgery or for rehabilitation after surgery.)
Covered Medical Expenses are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

Lab/X-ray Expenses (Requires an AU Health Center referral)
Covered Medical Expenses for the use of diagnostic X-ray and laboratory services are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.
Note: The Deductible is waived for covered laboratory expenses that are ordered by a SHC provider during a SHC visit.

Emergency Room Expenses (No referral required)
Covered Medical Expenses for the treatment of an Emergency Medical Condition are payable as follows:
In-Network Care: 80% of the Negotiated Charge after a $50 copay (waived if admitted).
Out-of-Network Care: 80% of the Reasonable Charge after a $50 deductible.

Mental Health and Substance Abuse Benefits

Inpatient Expenses (Please refer to Inpatient Admission Pre-Certification Requirements)
Covered Medical Expenses for the treatment of a mental health condition or for alcohol and substance abuse while confined as an inpatient in a hospital or facility licensed for such treatment are payable on the same basis as for any other Sickness. Pre-certification is required for all inpatient admissions.
For emergency admissions, the patient, patient's representative, Physician, or hospital must telephone within one business day following admission.
Inpatient mental health treatment is limited to a maximum of 45 days per Academic Year for any one condition or related mental health condition.
Inpatient substance abuse treatment is limited to a maximum of 60 days per Academic Year.
Inpatient detoxification treatment is limited to a maximum of 12 days per Academic Year.
Covered Medical Expenses also include the charges made for treatment received during partial hospitalization in a hospital or treatment facility.
When approved, benefits will be payable in place of an inpatient admission, whereby two days of partial hospitalization may be exchanged for one day of full hospitalization.
Prior review and approval must be obtained on a case-by-case basis by contacting Managed Care Concepts at (866) 750-2723.

Outpatient Expenses
Covered Medical Expenses for the treatment of a mental health condition, alcoholism, or substance abuse by a licensed or accredited health service organization, hospital, or by a fully licensed practitioner are payable as follows.

Mental Health Expenses
In-Network Care: 75% of the Negotiated Charge for the 1st through the 40th visit; and at 60% of the Negotiated Charge thereafter.

Out-of-Network Care: 75% of the Reasonable Charge for the 1st through the 40th visit; and at 60% of the Reasonable Charge thereafter.

Alcoholism and Drug Abuse Expenses
In-Network Care: 75% of the Negotiated Charge for the 1st through the 40th visit; and at 60% of the Negotiated Charge thereafter.
Out-of-Network Care: 75% of the Reasonable Charge for the 1st through the 40th visit; and at 60% of the Reasonable Charge thereafter.

Maternity Benefits

Maternity Expenses
Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other sickness. Covered Medical Expenses also include inpatient care for a minimum of 48 hours following vaginal delivery, or 96 hours following a cesarean section, for the mother and her newly born child (including newborn hearing screening).
Any decision to shorten such minimum coverages shall be made by the attending physician in consultation with the mother and done in accordance with the rules and regulations promulgated by the Department of Public Health. In such cases, covered services may include home visits, parent education, and assistance and training in breast or bottle-feeding.

Termination of Pregnancy Expenses
Covered Medical Expenses for voluntary termination of pregnancy are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 80% of the Reasonable Charge.
Covered Medical Expenses are subject to a maximum benefit payable of $200.

Additional Benefits

• Transgender Benefit Expenses
Medically necessary non-surgical treatment for transgender medical conditions, limited to office visits, lab tests, pharmacy and hormone therapy. Treatments covered are limited to a $3000 maximum per policy holder per academic year.

• Diabetic Equipment and Self-Management Education Program Expenses (Please note: syringes and diabetic testing supplies are covered under the Prescription Drug portion of the Plan)
Covered Medical Expenses for diabetic equipment, other than those provided under the Prescription Drug portion of the Plan, and self-management education programs, are payable on the same basis as any expense.

• High Cost Procedure Expenses
Covered Medical Expenses for high cost procedures in excess of $200, such as, but not limited to, outpatient diagnostic C.A.T. Scans, Magnetic Resonance Imaging, and laser treatments are payable as follows:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

• Dental Expenses
Covered Medical Expenses for the treatment of an Injury to sound, natural teeth are payable at 80% of the Actual Charge up to a maximum of $200 per Academic Year.
Covered Medical Expenses for the removal of wisdom teeth or a dental abscess are payable at 80% of the Actual Charge up to a maximum of $75 per tooth (inpatient) or to a maximum of $40 per tooth (outpatient).

• Learning Disability Testing Expenses
Covered Medical Expenses are payable as follows up to a maximum of $750 per Academic Year:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 80% of the Reasonable Charge.

• Durable Medical Equipment Expenses (Replacements are not covered)
Covered Medical Expenses are payable as follows:
In-Network Care: 70% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

• Temporomandibular Joint (TMJ) Dysfunction Expenses
Covered Medical Expenses are payable as follows up to a lifetime maximum of $5,000:
In-Network Care: 80% of the Negotiated Charge.
Out-of-Network Care: 60% of the Reasonable Charge.

• Ambulance Expenses
When a student's and provider's addresses at the time of service are more than 25 miles away from campus, covered Medical Expenses are payable at the following levels for the services of a professional ambulance to or from a hospital when required due to the emergency nature of a covered Accident or Sickness:
In-Network Care: 70% of the Negotiated Charge.
Out-of-Network Care: 70% of the Reasonable Charge.

• Women's Health Expenses
When a student's and provider's addresses at the time of service are more than 25 miles away from campus, covered Medical Expenses are payable for a routine annual (or more frequently, if prescribed by a Physician) Pap smear and mammogram.
Covered Medical Expenses are payable as follows:
In-Network Care: 100% of the Negotiated Charge with waiver of Deductible.
Out-of-Network Care: 100% of the Reasonable Charge with waiver of Deductible.

• Breast Reconstruction Surgery Following Mastectomy Expenses
Covered Medical Expenses include charges incurred by an insured person who is receiving benefits for a Medically Necessary mastectomy and who elects breast reconstruction after a mastectomy for: reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and fibromyalgia/myofacial pain; treatment of physical complications of all stages of mastectomy, including lymphedemia.
Covered Medical Expenses are payable on the same basis as any other mastectomy expense.

• Prostate Cancer Screening Expenses
Covered Medical Expenses include one annual (or more frequently if recommended by a Physician) digital rectal exam and Prostate Specific Antigen (PSA) test. Covered Medical Expenses are payable on the same basis as any other expense.
Covered Medical Expenses are payable for charges incurred by an insured person for screening of cancer in accordance with the latest screening guideline issued by the American Cancer Society for all ages, family histories and frequencies.
Covered Medical Expenses are payable on the same basis as any expense with waiver of the Plan Deductible.

• Primary and Preventive Care Expenses For Children
Covered Medical Expenses are payable on the same basis as any other illness or Injury for the primary and preventive care of covered dependent children under age 21. Coverage includes initial well child exam, unlimited routine Physician's office visits, including routine tests and immunizations, for covered dependent children up to age 12 per Academic Year. For covered dependent children age 12 to 21, coverage is provided for a maximum of three routine Physician's office visits, including routine tests and immunizations per Academic Year.

• Prescription Contraceptive Medical Expenses
Covered Medical Expenses are payable on the same basis as any other expense with waiver of the Plan Deductible. Covered Medical Expenses also include any expenses incurred for office visits in conjunction with the administration and management of a covered Prescription contraceptive. Any care received within 25 miles of the University without a prior referral from the Student Health Center will be excluded from coverage and will not be paid.
Coverage of oral contraceptives, Lunelle, Depo-Provera, contraceptive patch, and contraceptive ring are provided under the Prescription Drug portion of the Plan. Expenses incurred for office visits in conjunction with the administration of a covered Prescription contraceptive are provided under the Medical portion of the Plan.

• Emergency Contraception
Covered Medical Expenses are payable on the same basis as any other expense.

Any care received within 25 miles of the University without a prior referral from the Student Health Center will be excluded from coverage and will not be paid. Emergency Contraception is now available at most pharmacies without a prescription. Students should call their local pharmacy to see if they carry Emergency Contraceptives. Students can also call Managed Care Concepts Nurse Line at (866) 751-2723 for recommendations.

• Prescription Drug Benefit Expenses
Covered Medical Expenses for outpatient Prescription Drugs associated with a covered Sickness or covered Accident which occurs during the Academic Year are payable as follows with a $4,000 Academic Year Maximum:

A $10 Copay applies for each Generic Prescription Drug, a $25 Copay applies for each Formulary Brand Prescription Drug, and a $45 Copay for each Non-Formulary Brand Prescription Drug. This Pharmacy benefit is provided to cover Prescriptions associated with a covered Sickness or covered Accident occurring during the Academic Year.

Medications excluded from this benefit include, but are not limited to, allergy sera, allergy medications, all acne medications, drugs whose sole purpose is to promote or to stimulate hair growth, appetite suppressants, smoking deterrents, immunization agents and vaccines, and non-self injectables.

Prior authorization is required for some medications.

Students and Providers: For assistance, or for determination if a specific drug is excluded or requires prior authorization, please contact the WellDyneRx customer service department at (888) 479-2000. Benefits are paid only when Prescriptions are filled at a Participating Pharmacy. Please use your GM-Southwest ID card when obtaining your Prescription Drugs.

Additional Optional Benefits Available:

As a participant in the Student Health Insurance Plan, you can also take advantage of the following services, discounts, and programs. These services, discounts, and programs are not underwritten by Pan-American Life Insurance Company. Please visit www.myaustudentinsurance.com to enroll. You must enroll in the optional plans by October 1st.

Davis Vision Discount Program:

Who is Davis Vision?
Davis Vision is one of the nation's leading managed vision and eye care providers. They administer vision care services and products for 55 million people nationwide. Davis Vision offers a full line of vision care services through the Discount Vision Program. This program is based on annual enrollment which includes two routine eye exams covered in full with significant discounts on eyeglasses and contact lenses. (This is purely a discount program. All existing vision benefits associated with your health plan still apply).

How the plan works. . .
• Call the network provider of your choice and schedule an appointment.
• Identify yourself as a member of the American University Student Program.
• Provide the office with your student identification number.
It's that easy to receive services. The provider's office will verify your eligibility for services, and no claim forms or ID cards are required!

Who are the network providers?
You must choose a Davis Vision contracted provider or contracted retail location for your services. All Davis Vision providers are licensed providers who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained.

24-hour member services
An Interactive Voice Response (IVR) System is available from Davis Vision 24-hours a day, seven days a week. The IVR system provides the names and locations of Davis Vision providers near you. Or, you may visit the Davis Vision Web site at www.davisvision.com and click on "Find a Nearby Doctor". To speak with a Davis Vision Member Service Representative or access the IVR system, simply call 1-800-999-5431. Davis Vision Member Service Representatives are available from 8 AM to 11 PM, Monday through Friday, 9 AM to 4 PM Saturday, and 12 PM to 4 PM on Sunday. A Member Service Representative can answer questions regarding all aspects of your Vision Care Advantage benefits.

Savings on replacement contact lenses
Free membership and access to a mail order replacement contact lens service, Lens 123, providing a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 123 website at www.Lens123.com.

Information about Laser Vision Correction Services:
Davis Vision is pleased to provide you with the opportunity to receive Laser Vision Correction Services at significant discounts through a network of experienced, credentialed surgeons (please note that some providers have flat fees equivalent to these discounts). For more information, please visit our website at www.davisvision.com or call 1-800-999-5431.

Davis Vision's Schedule of Charges*:

Complete Examination (one per semester)	Covered in full
	Your costs and discounts
Contact Lens Evaluation	15% off Usual and Customary
Frames	
Priced up to $70 retail	$40
Priced above $70 retail	$40 plus 10% off the amount over $70
Lenses (Uncoated Plastic)	
Single Vision	$35
Bifocal	$55
Trifocal	$65
Lenticular	$110
Lens Options (Add to lens prices above)	
Standard Progressive	$75
Premium Progressive	$125
Glass Lenses	$18
Polarized Lenses	$75
High Index Lenses	$55
Polycarbonate Lenses	$30
Scratch-Resistant Coating	$20
Anti-Reflective Coating	$45
Ultraviolet Coating	$15
Solid Tint	$10
Gradient Tint	$12
Photochromic Lenses	$35
Plastic Photosensitive Lenses	$65
Contact Lenses	
Conventional	20% off Usual and Customary

Disposable/Planned Replacement ---------- 10% off Usual and Customary
Lens 1-2-3® Contact Lens Replacement Program**---------- Up to 60% off Retail Prices
Other Products
Laser Vision Care Services---------- Up to 25% off Usual and Customary †
Non-prescription Sunglasses ---------- 20% off Usual and Customary
Other Ancillary Products/Solutions ---------- 10% off Usual and Customary

* At Wal-Mart, locations, members will receive Wal-Mart's everyday low price on frames, lenses, and contact lens purchases.
** Not all states require contact lens prescription release.
† Or receive an additional 5% discount on any advertised specials – whichever is lower.

Davis Vision Rates:

Student:	$87 - Annual
Spouse/Domestic partner:	$87 - Annual
Each Child:	$87 - Annual

This vision program is not underwritten by Pan American Life Insurance Company.

CareFirst BlueChoice Dental HMO

A voluntary dental program is also available at an additional cost. As a CareFirst BlueChoice Dental HMO Plan member you will find that our emphasis is on preventive care. You'll pay a minimal office visit Copay when you visit your participating primary care dentist for most preventive and diagnostic services such as routine checkups, cleanings and X-rays. Other services such as crowns, bridges, dentures, root canals, and orthodontics are also covered with an additional Co-pay. Please visit www.myaustudentinsurance.com for additional information or to enroll in the dental plan.

CareFirst BlueChoice Dental HMO Rates	Premium 9/1/11 - 8/31/12
Student	$128
Student & Spouse/Domestic Partner	$247
Student and Family	$360

This dental program is not underwritten by Pan American Life Insurance Company.
To enroll in the Davis Vision and/or CareFirst Dental Plan Option for coverage effective September 1, 2011 through August 31, 2012, please go to www.myaustudentinsurance.com. Register and login to the website with your personal username and password. Select "Enrollment". Simply follow the online prompts to make your payment. You must enroll in the Optional plans no later than October 1, 2011.
New Students wishing to enroll for Spring Coverage effective January 1, 2012 through August 31, 2012 must complete and submit an Enrollment Form no later than February 1, 2012.
New Students wishing to enroll for Summer Coverage effective May 1, 2012 through August 31, 2012 must complete and submit an Enrollment Form no later than June 15, 2012.
*Please note: Only New Students are eligible to enroll for the Spring/Summer Davis Vision and CareFirst BlueChoice Dental HMO Plans.

Nurseline Services
Nurseline services are available for members to call with questions 24 hours a day, seven days a week. So whether it is cold symptoms, a rash, or another non urgent/non emergency condition, you can call to speak directly to a qualified nurse.
To reach the Managed Care Concepts Nurse Line, please call (866) 751-2723.

Managed Care Concepts Utilization Review Services
* Pre-certification process - determines medical necessity for health related procedures ordered by a members physician
* Concurrent Review - continuing collection of clinical data to support continued services
* Retrospective Review - determines medical necessity after services have been rendered
* Effective communication with the member's health benefit plan administrators and service providers
To reach the Managed Care Concepts Utilization Review Department, please call (866) 750-2723.

These Nurse Line Services and Utilization Review Services are not underwritten by Pan American Life Insurance Company.

General Provisions

State Mandated Benefits

The Plan will always pay benefits in accordance with any applicable District of Columbia Insurance Law(s).

Subrogation/Reimbursement Right of Recovery Provision

Immediately upon paying or providing any benefit under this Plan, The Company shall be subrogated to all rights of recovery an insured person has against any party potentially responsible for making any payment to an insured person, due to an insured person's Injuries or illnesses, to the full extent of benefits provided, or to be provided by The Company. In addition, if an insured person receives any payment from any potentially responsible party, as a result of an injury or illness, The Company has the right to recover from, and be reimbursed by, the insured person for all amounts this Plan has paid, and will pay as a result of that Injury or illness, up to and including the full amount the insured person receives, from all potentially responsible parties. An "insured person" includes, for the purposes of this provision, anyone on whose behalf this Plan pays or provides any benefit, including but not limited to the minor child or dependent of any insured person, entitled to receive any benefits from this Plan.
As used in this provision, the term "responsible party" means any party possibly responsible for making any payment to an insured person or on an insured person's behalf due to an insured person's Injuries or illnesses or any insurance coverage responsible making such payment, including but not limited to:
• Uninsured motorist coverage;
• Underinsured motorist coverage;
• Personal umbrella coverage;
• Med-pay coverage;
• Workers compensation coverage;
• No-fault automobile insurance coverage; or
• Any other first party insurance coverage.
The insured person shall do nothing to prejudice The Company's subrogation and reimbursement rights.
The insured person shall, when requested, fully cooperate with The Company's efforts to recover its benefits paid. It is the duty of the insured person to notify The Company within 45 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim, to recover damages, due to Injuries sustained by the insured person.
The insured person acknowledges that this Plan's subrogation and reimbursement rights are a first priority claim against all potential responsible parties, and are to be paid to The Company before any other claim for the insured person's damages. This Plan shall be entitled to full reimbursement first from any potential responsible party payments, even if such payment to the Plan will result in a recovery to the insured person, which is insufficient to make the insured

person whole, or to compensate the insured person in part or in whole for the damages sustained. This Plan is not required to participate in or pay attorney fees to the attorney hired by the insured person to pursue the insured person's damage claim. In addition, this Plan shall be responsible for the payment of attorney fees for any attorney hired or retained by this Plan. The insured person shall be responsible for the payment of all attorney fees for any attorney hired or retained by the insured person or for the benefit of the insured person.

The terms of this entire subrogation and reimbursement provision shall apply. This Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party, and regardless of whether the settlement or judgement received by the insured person identifies the medical benefits this Plan provided. This Plan is entitled to recover from any and all settlements or judgments, even those designated as "pain and suffering" or "non-economic damages" only.

In the event any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the insured person and this Plan agree that The Company shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Non-Duplication of Benefits

This provision applies if a covered student:

(a) Is covered by any other group or blanket health care plan; and

(b) Would, as a result, receive medical expense or service benefits in excess of the actual expenses incurred.

In this case, the medical expense benefits the Plan will pay will be reduced by such excess.

Exclusions

The Student Health Insurance Plan neither covers nor provides benefits for the following:

1. Expenses incurred for a treatment, service, or supply, which is not Medically Necessary, as determined by The Company, for the diagnosis, care, or treatment of the Sickness, clinically significant mental illness, or Injury involved. This applies even if they are prescribed, recommended, or approved, by the person's attending Physician, or dentist. In order for a treatment, service, or supply, to be considered Medically Necessary, the service or supply must:

- Be care, or treatment, which is likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved, and the person's overall health condition;
- Be a diagnostic procedure which is indicated by the health status of the person, and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the Sickness or Injury involved, and the person's overall health condition; and
- As to diagnosis, care, and treatment, be no more costly (taking into account all health expenses incurred in connection with the treatment, service, or supply), than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, The Company will take into consideration information relating to the affected person's health status, reports in peer reviewed medical literature, reports and guidelines published by nationally recognized health care organizations that include supporting scientific data, generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care, or treatment, the opinion of health professionals in the generally recognized health specialty involved, and any other relevant information brought to The Company's attention.

In no event will the following services or supplies be considered to be Medically Necessary:

- Those that do not require the technical skills of a medical, a mental health, or a dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, or any persons who is part of his or her family, any healthcare provider, or healthcare facility; or

- Those furnished solely because the person is an inpatient on any day on which the person's Sickness or Injury could safely, and adequately, be diagnosed, or treated, while not confined; or
- Those furnished solely because of the setting, if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office, or another less costly setting.

2. Expenses incurred as a result of dental treatment, except for treatment resulting from Injury to sound, natural teeth, a dental abscess, or for removal of wisdom teeth, as provided elsewhere in the Policies.

3. Expenses incurred for services normally provided without charge by the Policyholder's Student Health Center, infirmary, hospital, or by health care providers employed by the Policyholder.

4. Expenses incurred for eye refractions, vision therapy, radial keratotomy, eyeglasses, contact lenses (except when required after cataract surgery), or other vision or hearing aids, or Prescriptions or examinations except as required for repair caused by a covered Injury.

5. Expenses incurred as a result of Injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way, including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense, so long as they are not taken against persons who are trying to restore law and order.

6. Expenses incurred as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a scheduled airline maintaining regular, published schedules on a regularly established route.

7. Expenses incurred as a result of an Injury or Sickness for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

8. Expenses incurred as a result of Injury sustained or Sickness contracted while in the service of the armed forces of any country. Upon the Covered Person entering the armed forces of any country, the unearned pro-rated premium will be refunded to the Policyholder.

9. Expenses incurred for treatment provided in a governmental hospital unless there is a legal obligation to pay such charges in the absence of insurance.

10. Expenses incurred for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies, which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons. This exclusion will not apply to the extent needed to:
(a) Improve the function of a part of the body that is not a tooth or structure that supports the teeth, and is malformed as a result of a severe birth defect (including harelip and webbed fingers or toes), or as direct result of disease, or surgery performed to treat a Sickness or Injury.
(b) Repair an Injury which occurs while the insured person is covered under the Student Health Insurance Plan. Surgery must be performed in the Academic Year of the Accident, which causes the Injury, or in the next Academic Year.
For reconstructive breast surgery following a mastectomy, including (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas, in a manner determined by the attending Physician and patient to be appropriate.

11. Expenses for Injuries sustained as a result of a motor vehicle accident to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

12. Expenses incurred as a result of allergy testing, shots and injections, preventive medicines, serums, vaccines.

13. Expenses incurred for any services rendered by a family member of an insured person's immediate family or a person who lives in the insured person's home.

14. Expenses incurred by an insured person who is not a United States Citizen for services performed within the insured person's home country if the insured person's home country has a socialized medicine program (or provides national health).

15. Expenses incurred for the treatment of temporomandibular joint (TMJ) dysfunction and associated myofascial pain in excess of $5,000 per lifetime.

16. Expenses incurred for custodial care. Custodial care means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes room and board and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to, by whom they are prescribed, or by whom they are recommended, or by whom or by which they are performed.

17. Expenses incurred after the date insurance terminates for an insured person except as may be specifically provided in the Extension of Benefits provision.

18. Expenses covered by any other valid and collectible medical, health, or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

19. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

20. Expenses for treatment for Injury to the extent benefits are payable under any state no-fault automobile coverage, or any first-party medical benefits payable under any other mandatory no-fault law.

21. Expenses for contraceptive methods, devices, or aids; charges for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures; and elective sterilization or its reversal, unless otherwise provided in the Policies.

22. Expenses incurred as a result of commission of a felony.

23. Expenses incurred for which any member of the insured person's immediate family has any legal obligation to pay.

24. Expenses incurred for the treatment of Accidents or Injuries resulting from the participation in intercollegiate sports (participation in sports clubs or intramural athletic activities is not excluded).

25. Expenses incurred for repair or replacement of existing artificial limbs, orthopedic braces, or orthotic devices, unless otherwise provided in the Policies.

26. Expenses incurred for or in connection with procedures, services, or supplies that are, as determined by The Company, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

- There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature, to substantiate its safety and effectiveness, for the disease or Injury involved; or
- If required by the FDA, approval has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by

the treating facility, or by another facility studying the same drug, device, procedure, or treatment, states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if The Company determines that:

- The disease can be expected to cause death within one year, in the absence of effective treatment; and
- The care or treatment is effective for that disease, or shows promise of being effective for that disease, as demonstrated by scientific data.

In making this determination, The Company will take into account the results of a review by a panel of independent medical professionals. They will be selected by The Company . This panel will include professionals who treat the type of disease involved.

- Have been granted treatment investigational new drug (IND), or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial, sponsored by the National Cancer Institute; or
- The Company determines that available, scientific evidence demonstrates that the drug is effective, or shows promise of being effective, for the disease.

27. Expenses for treatment of Injury or Sickness to the extent payment is made, as a judgement or settlement, by any person deemed responsible for the Injury or Sickness (or their insurers).

28. Expenses incurred for, or related to, services, treatment, education testing, or training related to learning disabilities or developmental delays unless otherwise provided in the Policies.

29. Expenses incurred for, or related to, sex change surgery or to any treatment of gender identity disorders, except as specifically provided in the policies.

30. Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in the Policies.

31. Expenses incurred as a result of treatment for acne.

32. Expenses incurred for gastric bypass, and any restrictive procedures, for weight loss.

33. Expenses incurred for breast reduction/mammoplasty.

34. Expenses incurred for gynecomastia (male breasts).

35. Expenses incurred for sinus surgery, except for acute purulent sinusitis.

36. Expenses for charges that are not Reasonable Charges, as determined by The Company.

37. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of their training in that field.

38. Expenses incurred for chiropractic care.

39. Expenses incurred for Elective Treatment or elective surgery except as specifically provided elsewhere in the Policies and performed while the Policies are in effect.

Any exclusion listed will not apply to the extent that coverage is specifically provided by name in the Policies, or coverage of the charges is required under any law that applies to the coverage.

Extension of Benefits

If an insured person is confined to a hospital on the date his or her insurance terminates, expenses incurred after the termination date and during the continuance of that hospital confinement shall be payable in accordance with the Policies, but only while they are incurred during the 90-day period following such Termination of Insurance.

Termination of Insurance

Benefits are payable under the Policies only for those Covered Medical Expenses incurred while the Policies are in effect as to the insured person. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

Claim Procedure

On occasion, the claims investigation process will require additional information in order to properly adjudicate the claim. This investigation will be handled directly by:

GM-Southwest, Inc.
P.O. Box 6000
Frisco, TX 75034
(877) 885-3298.

Customer Service Representatives are available 8:30 a.m. to 5:00 p.m., Monday through Friday (EST) for any questions.

1. Bills must be submitted within 90 days from the date of treatment.
2. Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
3. Any itemized medical bills should include the student ID number, date of service, name of provider, CPT code, diagnosis code, and should be mailed promptly to the above address. In the event of a disagreement over the payment of a claim, a written request to review the claim must be mailed to GM-Southwest, Inc. within 60 days from the date appearing on the Explanation of Benefits.

Appeals and Complaints Procedure

Our complaints and appeals process is designed to address the insured person's coverage issues, complaints and problems. If you have a coverage issue or other problem, call the Customer Service toll-free number on your ID card or review your Student Health Insurance Plan documents for more information.
You can also contact Customer Service at the toll-free number on your ID card for more information. A representative will address your concern. If you are dissatisfied with the outcome of your initial contact, you may appeal the decision. Your appeal will be decided in accordance with the procedure applicable to your Plan. You may also submit your request, in writing, along with all pertinent correspondence, to:

GM-Southwest, Inc.
P.O. Box 6000
Frisco, TX 75034
(877) 885-3298

You may also seek additional information on the internet for the applicable State Insurance Department or other agency regarding your rights, including how to obtain regulatory review of the insured person's concerns.

External Review

The Company has developed an external review process to give insured persons an added option of requesting an objective and timely external review of certain coverage denials. Once our internal coverage decision review process is exhausted, eligible insured persons may elect external review if the coverage denial for which the insured person would be financially responsible involves more than $500 (or the applicable amount specified by your state) and is based on lack of Medical Necessity or on the experimental or investigational nature of the proposed service or treatment.
An external review organization will refer the case to review by an independent Physician with appropriate expertise in the area in question. After all necessary information is submitted, external review will generally be decided within 30 days of the request. Expedited reviews are available when an insured person's Physician certifies that a delay in service would jeopardize the insured person's health. Once the review is complete, the Student Health Insurance Plan will abide by the decision of the external reviewer.
Certain states mandate external review of additional benefit or service issues or require a filing fee. In addition, certain states mandate the use of their own external review providers for Medical Necessity and experimental/investigational coverage decisions. For further details regarding your Plan's grievance and external review process, call the Customer Service toll-free number on your ID card. You may also call your State Insurance or Health Department for additional information regarding state mandated external review procedures.

Prescription Drug Claim Procedure

When obtaining a covered Prescription, please present your GM-Southwest, Inc. ID card, with the WellDyneRx logo, to a Participating Pharmacy along with your applicable Copay. The Pharmacy will submit a claim for your prescription drug. Claim Forms and claims status information can be obtained by contacting the WellDyneRx Customer Service Department at (888) 479-2000. When you need to fill a Prescription and do not have your ID card with you, you may obtain your Prescription from a Participating Pharmacy and be reimbursed by submitting a completed GM-Southwest, Inc. Prescription Drug claim form. You will be reimbursed for covered medications directly by GM-Southwest, Inc.. Please note, in addition to your Copay, you may be required to pay the difference between the retail price you paid for the drug and the amount GM-Southwest, Inc. would have paid if you had presented your ID card and the Pharmacy had billed GM-Southwest, Inc. directly. When submitting a claim, please include all Prescription receipts, indicate that you attend American University, and include your name, address, and student identification number.

Accident Death and Dismemberment Benefit

The Policies provide $1,000 for accidental loss of life, two limbs, both eyes or one limb and one eye, and $500 for accidental loss of one limb or one eye.

Benefits are payable limited to one year from the date of the accident.

This benefit is paid in addition to all other benefits.

Mondial Services - Emergency Travel Assistance Services

These services are designed to protect American University students and/or eligible dependents anywhere in the world. If you experience a medical emergency, you have access to a comprehensive package of emergency services provided by Mondial Assistance. Eligible participants have immediate access to doctors, hospitals, pharmacies, and other services by simply calling the Mondial Assistance team 24 hours a day, 365 days a year. Mondial Assistance's worldwide services include medical consultations and referrals, domestic and international hospital admission guarantees, emergency medical transportation, prescription assistance, lost luggage assistance, legal and interpreter assistance, and travel information

such as visa and passport requirements, travel advisories. You may reach Mondial Assistance at 1-800-929-1612 or collect at 804-965-8076. Please contact GM-Southwest, Inc. at 877-885-3298 with any questions or visit www.myaustudentinsurance.com.

Repatriation/Medical Evacuation Benefit

Repatriation Benefit - $10,000 Maximum Benefit. If the Insured dies while insured under the policy, benefits will be paid up to $10,000 for preparing and transporting the remains of the deceased's body to his home country. This benefit is limited to the maximum benefit specified above. Repatriation requires prior approval of the Claims Office.

Medical Evacuation Benefit - $10,000 Maximum Benefit. When hospital confined for at least five consecutive days, and recommended and approved by the attending physician, benefits will be paid up to $10,000 for the evacuation of the insured to his natural country. This benefit is limited to the Maximum Benefit specified above and all services must be necessary for the care and treatment of the insured. Any expenses for Medical Evacuation require prior approval of the Claims Office.

Important Note

Please keep this Brochure, as it provides a general summary of your coverage. A complete description of the benefits and full terms and conditions may be found in the Master Policies. If any discrepancy exists between this Brochure and the Policies, the Master Policies will govern and control the payment of benefits.

This student Health Insurance Plan fulfills the definition of Creditable Coverage explained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. At any time should you wish to receive a certification of coverage, please call the Customer Service number on your ID card.

Offered by:
GM-Southwest, Inc.

Administered by:
GM-Southwest, Inc.
P.O. Box 6000
Frisco, TX 75034
(877) 885-3298
www.myaustudentinsurance.com

Issued by:
Pan-American Life Insurance Company

Policy Numbers 203107 – F
203107 – S
203107 – SU

Notice

GM-Southwest, Inc. considers nonpublic personal member information confidential and has policies and procedures in place to protect the information against unlawful use and disclosure. When necessary for your care or treatment, the operation of your health plan, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, Pharmacies, hospitals, and other caregivers), vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. Participating Network/Preferred Providers are also required to give you access to your medical records within a reasonable amount of time after you make a request. By enrolling in the Plan, you permit us to use and disclose this information as described above on behalf of yourself and your dependents. To obtain a copy of our Notice of Privacy Practices describing in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Customer Service number on your ID card or visit our website at www.gmsouthwest.com.

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefit if false information materially related to a claim was provided by the applicant.