



CASE WESTERN RESERVE
UNIVERSITY EST. 1826

OPTIONAL DEPENDENT MEDICAL PLAN 2008-2009

IMPORTANT

The Medical Plan benefits described herein are subject to the provisions of the Plan Document. The Plan Document may be reviewed at University Health Service, 2145 Adelbert Road.

Sponsored By:
CASE WESTERN RESERVE UNIVERSITY
Cleveland, Ohio

Administered By:
Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
Toll Free: 877-850-6038

TELEPHONE DIRECTORY

University Health Service

2145 Adelbert Road 216-368-2450

Medical Plan Information 216-368-3050

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ENROLLMENT FORM (for Students of Case Western Reserve University School of
Medicine, the Cleveland Clinic Lerner College of Medicine, and Case Western Reserve
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ELIGIBILITY

1. The spouse or domestic partner of a covered student residing with the covered student.
2. Newborn enrolled within 30 days of birth and residing with the covered student.
3. Dependent child/ren under the age of 19 years residing with the covered student.
4. Newlyweds, dependents experiencing a loss of coverage with another health plan and dependents arriving from abroad. All must apply for coverage within 30 days of these events. Contact University Health Service for details.

NOT ELIGIBLE TO RECEIVE COVERAGE:

1. Students who are eligible for coverage under Case Western Reserve University Student Medical Plan.
2. Employees of Case Western Reserve University who are eligible for Benelect.

PERIODS OF COVERAGE AND COST

Medical coverage for spouse, domestic partner, and dependent child/ren may only be purchased if the student has purchased the Student Medical Plan coverage for students.

Coverage may be purchased on a per semester basis or on an annual basis. **ENROLLMENT IS NOT AUTOMATIC.** You must renew the coverage each semester or each year.

Students enrolled at Case Western Reserve University School of Medicine, Case Western Reserve University School of Dental Medicine (MSD) and Cleveland Clinic Lerner College of Medicine should refer to page 13 for coverage dates, enrollment and payment information.

All other students enrolled at Case Western Reserve University refer to page 12 for coverage dates, enrollment and payment information.

If coverage is desired, complete and return to University Health Service the enclosed enrollment form and appropriate premium, in the form of a check or money order, payable to Case Western Reserve University. **The completion of an Affidavit is necessary for the enrollment of a domestic partner. Forms are available at University Health Service.** Once paid, no portion of the premium for dependent coverage is refundable.

IMPORTANT DEFINITIONS

Injury

– Means bodily damages:

- a. caused directly and independently of all other causes by an accident; and,
- b. which results in loss covered by the Plan.

Sickness

– Means illness or disease for which treatment is received while the person is covered under this Plan.

Disability

– Means either a Sickness or Injury.

Pre-existing Condition

– Means a Sickness or Injury for which medical advice, diagnosis, treatment, services or supplies were rendered within the 12 months prior to the effective date of coverage.

Routine Care

– Means any medical service that is performed for preventative purposes or performed in the absence of a specific diagnosis.

Plan Year

– Means fiscal year as described under period of coverage above.

NETWORK INFORMATION

Case Western Reserve University Optional Dependent Medical Plan, subject to the outlined benefits, limits and exclusions, protects the participant during the term for which the fee has been paid. The Plan reserves the right to coordinate benefits with any other medical coverage.

Participants of the Optional Dependent Medical Plan are encouraged to access a national network of Preferred Providers in the Aetna network. Participants may realize substantial savings by utilizing preferred providers.

A complete listing of Participating Providers is available through the internet by accessing Aetna's DocFind® Service at www.aetnastudenthealth.com. Click on Find Your School and enter 474889 as your policy number. Additionally, information regarding Preferred Providers can be obtained by contacting Aetna Student Health at 877-850-6038.

Failure to utilize a network provider, will result in a benefit reduction to 60% of covered charges.

In the case of a medical emergency as determined by the claims administrator, a participant who obtains health care from an out-of-network provider will be subject to the in-network limits and restrictions with respect to such care. When hospital or medical care is required because of a Sickness or Injury eligible for benefits under this Plan, the reasonable and customary expense actually incurred will be paid, up to the specified limits for each Sickness or Injury.

MEDICAL COVERAGE

Primary Care or Specialist Office Visit: \$20 co-payment* due at the time of service, 80% of remaining balance is paid for by The Plan, 20% of remaining balance is the responsibility of the participant.

**Co-payments do not accumulate toward the out-of-pocket maximums.*

Urgent Care Facility: \$30 co-payment* due at the time of service, 80% of remaining balance is paid for by The Plan, 20% of remaining balance is the responsibility of the participant.

**Co-payments do not accumulate toward the out-of-pocket maximums.*

Emergency Room: \$50 co-payment* due at the time of service (waived if admitted), 80% of remaining balance is paid for by The Plan, 20% of remaining balance is the responsibility of the participant.

**Co-payments do not accumulate toward the out-of-pocket maximums.*

Outpatient Services*:

In-Network: 80% of eligible charges are paid for by The Plan, the remaining 20% of charges are the responsibility of the participant.

Out-of-Network: 60% of eligible charges are paid for by The Plan, the remaining 40% of charges are the responsibility of the participant.

**This includes outpatient maternity services.*

Mammography

The Plan will pay the cost, up to \$85 per exam, for routine mammograms as follows:

<i>Participant Age (Years)</i>	<i># Exams</i>
35 but less than 40	1 every 4 Plan Years
40 but less than 50	1 every 2 Plan Years (1 per Plan Year if certified as high risk for breast cancer)
Over 50	1 per Plan Year

Well-Child Care

The Plan will pay charges incurred for outpatient Routine Care of a covered Dependent child under age 9, including Physician's exams, lab tests, immunizations and other routine services, up to a maximum benefit of \$500 per Plan Year.

In-Network 80% plans pays/ 20% participant pays

Out-of-Network 60% plan pays/ 20% participant pays

Inpatient Services*:

In-Network: 80% of eligible charges are paid for by The Plan, the remaining 20% of charges are the responsibility of the participant.

Out-of-Network: 60% of eligible charges are paid for by The Plan, the remaining 40% of charges are the responsibility of the participant.

**This includes inpatient maternity services.*

Optional Dependent Medical Plan Out of Pocket Maximum:

In-Network: \$5,000 per Plan Year

Out-of-Network: \$7,500 per Plan Year

The Plan will pay 100% of the excess of eligible expenses incurred after the out-of-pocket maximum has been met up to a maximum benefit of \$250,000 per Plan Year.

Optional Dependent Medical Plan Year and Lifetime Maximum:

Medical and Prescription Benefits Plan Year Maximum: \$250,000

Medical and Prescription Benefits Lifetime Maximum: \$2,000,000

Routine newborn nursery care paid up to a maximum of \$5,000 for enrolled newborn.

MENTAL HEALTH AND CHEMICAL DEPENDENCY COVERAGE

In-Network: 80% of eligible charges are paid for by The Plan, the remaining 20% of charges are the responsibility of the participant.

Out-of-Network: 60% of eligible charges are paid for by The Plan, the remaining 40% of charges are the responsibility of the participant.

Outpatient Mental/Nervous Benefit Limitations: Coverage under The Plan is limited to 26 visits per Plan Year for: diagnosis, treatment, couples counseling, legally rendered by a licensed psychiatrist, psychologist or social worker. Such outpatient service may be provided in a physician's office, hospital outpatient department, community mental health facility or an alcoholism or drug abuse treatment facility.

Inpatient Mental/Nervous:

In-Network: 80% of eligible charges are paid for by The Plan, the remaining 20% of charges are the responsibility of the participant.

Out-of-Network: 60% of eligible charges are paid for by The Plan, the remaining 40% of charges are the responsibility of the participant.

Inpatient Mental/Nervous Benefits Plan Year Maximum: \$20,000

PRESCRIPTION COVERAGE

Prescription drug expenses are covered under the medical plan the same as other expenses related to a covered sickness or injury. Participants enrolled in the Optional Dependent Medical Plan are automatically enrolled in the drug plan, administered by Envision Rx Options.

The plan includes a co-payment that is required to be paid when a prescription is purchased. Participants will pay their predetermined co-payment and the plan will pay the remainder of the cost. The Plan will pay up to \$5,000 under the co-payment schedule. Once the Plan has paid \$5,000 under the co-payment schedule, 60% of eligible charges are paid for by The Plan, the remaining 40% of charges are the responsibility of the student. Prescription reimbursement paid by The Plan in excess of \$5,000 will be applied toward the Plan Year maximum of \$250,000.

Co-payment Schedule

Category	Retail (30-day)	Mail Order (90-day Supply)
OTC (Prilosec, Claritin, Claritin D, Loratadine, Loratadine D)*	\$5.00	\$15.00
Generic	\$15.00	\$30.00
Brand	\$30.00	\$60.00
Non-Formulary	20% with \$50.00 paid by participant	20% with \$100.00 minimum paid by participant

Certain over the counter (OTC) medication are available. Participants are encouraged to consult their physician to determine if OTC Prilosec, OTC Claritin, OTC Claritin D, OTC Loratadine or OTC Loratadine D therapy is appropriate. If it is so determined, the participant's physician must write a prescription specifically for one of these medications and present it to the pharmacist to be eligible for reimbursement under the Plan.

In some cases, it may be necessary to pay the entire cost of the prescription and submit a claim form along with a pharmacy receipt to Envision Rx Options when a network pharmacy is used.

Prescription benefit cards and direct member reimbursement forms are located at <http://studentaffairs.case.edu/medicalplan/>

Address: Envision Rx Options
2181 E. Aurora Rd.
Suite 201
Twinsburg, OH 44087

To locate a network pharmacy, please visit www.envisionrx.com or call (800) 361-4542 for any customer service related issue. Please note that no prescriptions will be paid for at non-network pharmacies. The participant may be required to show his/her Envision Rx ID card at the point of purchase. The pharmacist will determine which category the prescription applies in order to collect the correct co-payment at the time of purchase. Envision Rx Options customer service representatives are available to help in this determination as well.

The mail order facility for this plan is Walgreens. In addition to receiving a ninety-day supply prescription through the mail, a ninety-day supply may be obtained with a properly written prescription from the participant's physician by visiting any Walgreens retail location.

MAIL ORDER

New prescriptions must be mailed to the mail service pharmacy or faxed from the participant's physician office on the Walgreens Healthcare Plus physician fax form. The form is located at www.walgreensmail.com. For long-term medications needed right away: the participant should request two prescriptions from his/her physician – one for a small supply to fill at a participating retail pharmacy and one for a long-term supply to fill through the mail. Most orders are shipped by the U.S. Postal Service. Controlled substances may require a signature upon receipt. Packaging does not show any indication that medications are enclosed. Include payment if applicable to avoid any delays. Do not send cash. Make check payable to Walgreens Healthcare Plus. Credit cards are accepted.

Allow 2 weeks for delivery

Mail Pharmacy Customer Service:

1-800-992-2655 (TTY 1-800-925-0178)

Monday – Friday 8:00 a.m. – 8:00 p.m. (Eastern)

Saturday 8:00 a.m. – Noon (Eastern)

Refills by phone:

1-800-749-0009

Internet:

www.walgreensmail.com

DENTAL COVERAGE

Coverage is provided per the benefits outlined in the Plan for injury to sound, natural teeth. Participants are eligible for the following services only when obtained from Case Western Reserve University School of Dental Medicine.

- Two oral exams and evaluations, including a dental and medical history per Plan Year at 100% coverage
- Two oral cleanings per Plan Year at 100% coverage
- Periodic Bite Wing X-rays per Plan Year at 100% coverage
- Emergency pain relief at the Dental Clinic (or the UH Emergency Room when the Dental Clinic is closed) at 100% coverage
- 20% discount on all other dental services offered at the Case Western Reserve University School of Dental Medicine

Services are provided at Case Western Reserve University School of Dental Medicine by both pre-doctoral and doctoral students.

Appointments are necessary and may be made by calling the Case Western Reserve University Dental Clinic at 216.368.3200. Additionally, Student Medical Plan members (and their dependents) must present a valid Aetna Medical Plan ID card at the time of service.

Please Note: The Case Western Reserve University School of Dental Medicine closes periodically throughout the year. Oral cleanings are not provided when the clinic is closed. Emergency care is limited at this time but can be accessed by calling 216-368-3200.

Extra Discounts and Savings

Aetna VisionSM Discount Program

The Aetna Vision discount program helps you save on many eye care products, including sunglasses, contact lenses, non-prescription sunglasses, contact lens solutions and other eye care accessories. Plus, you can receive up to a 15% discount on LASIK surgery (the laser vision correction procedure).

Discount programs provide access to discounted prices and are NOT insured benefits.

Accidental Death and Dismemberment Benefit

This insurance coverage provides Accidental Death and Dismemberment coverage underwritten by United States Fire Insurance Company. Benefits are payable for the Accidental Death and Dismemberment of the eligible insureds of up to a maximum of \$10,000. (Exclusions and limitations may apply.)

To file a claim for Accidental Death and Dismemberment, please contact Aetna Student Health at (800) 966-7772 for the appropriate claim forms.

On Call International 24/7 Emergency Travel Assistance Services

These services are provided by On Call International and designed to protect Case Western Reserve University students and/or eligible dependents when traveling more than 100 miles from home, anywhere in the world. Medical Repatriation and Return of Mortal Remains services are also available at the participant's campus location.

If you experience a medical emergency while traveling more than 100 miles from your home or campus, you have access to a comprehensive group of emergency assistance services provided by On Call International. Eligible participants have immediate access to doctors, hospitals, pharmacies and other services when faced with an emergency while traveling. The On Call International Operations Center can be reached 24 hours a day, 365 days a year to provide services including: medical consultation and evaluation, medical referrals, foreign hospital admission guarantee, prescription assistance, lost luggage assistance, legal and interpreter assistance, and travel information such as Visa and passport requirements, travel advisories, etc.

Medical Evacuation and Return of Mortal Remains Services

In the event that a participant becomes injured and adequate medical facilities are not available locally, On Call International will use whatever mode of transport, equipment and personnel necessary to evacuate you to the nearest facility capable of providing required care. In the event of death of a participant, On Call International will render every possible assistance in return of mortal remains including locating a sending funeral home, preparing the deceased for transport, procuring required documentation, providing necessary shipping container as well as paying for transport.

Please note: Any third party expenses incurred are the responsibility of the Participant. An On Call International ID card will be supplied to you once you enroll in the Aetna Student Health Insurance Plan. Please remember to carry your On Call card and call toll-free within the U.S. at (866) 525-1956 or outside the U.S. call collect (dial U.S. access code) plus (603) 328-1956 in the event of an emergency when you are traveling. With one phone call, you will be connected to a global network of over 600,000 pre-qualified medical providers. On Call Operations Centers have worldwide assistance capabilities and are known throughout the world as a premier Emergency Assistance Services provider.

NOTE: On Call International pays for all Assistance Services it provides. All Assistance Services must be arranged and provided by On Call. On Call does not reimburse for services not provided by On Call.

The On Call International program meets and exceeds the requirements of USIA for International Students & Scholars.

Emergency Travel Assistance Services are administered by On Call International.

For questions about:

On Call International 24/7 Emergency Travel Assistance Services

Please contact:

If outside the U.S., call collect by dialing the U.S. access code plus (603) 328-1956. Please also visit www.aetnastudenthealth.com and visit your school-specific site for further information.

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

COVERAGE TERMINATION

Coverage terminates at 11:59 p.m. local time at the address of the University on the earliest of the dates indicated below:

- The end of the Period of Coverage;
- The date on which the Optional Dependent Medical Plan terminates;
- The date a participant enters military service; in this case a prorated refund will be available upon request;
- The end of the period for which the required payments have been received, if future payments cease.

If Case Western Reserve University terminates and does not replace this Optional Dependent Medical Plan, participants then receiving or entitled to receive benefits for a covered Sickness or Injury will continue to be covered for that Disability for up to 52 weeks following the date of termination or in accordance with the time period stated under the Optional Dependent Medical Plan, whichever is less.

Benefits payable during this period will not be more than the amounts provided under the Plan at the time the Disability began.

PLEASE NOTE: Any subsequent change in the limits provided under this Plan will not affect the benefits payable for a Disability for which benefits have been extended under this provision.

IDENTIFICATION CARD

Each dependent participating in the Optional Dependent Medical Plan will receive an ID Card; however, you do not need an ID card to be eligible to receive benefits. Once you have received your ID card, present it to the provider to facilitate prompt payment of your claims.

Note: Please be advised you will receive a unique Aetna member ID number on your membership card.

For lost ID cards, contact:

Aetna Student Health

or visit www.aetnastudenthealth.com, click on "Find Your School" and enter 474889 as your Policy Number.

CLAIM SUBMISSION

Please send all itemized medical bills as soon as possible after treatment is rendered to Aetna Student Health. Your name, identification number and Case Western Reserve University should be written clearly and attached to your medical bills. All information should be mailed to:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
877-850-6038

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

- Bills must be submitted within 90 days from the date of treatment.
- Payment for Covered Medical Expenses will be made directly to the hospital or Physician concerned unless bill receipts and proof of payment are submitted.
- If itemized medical bills are available at the time the claim form is submitted, attach them to the claim form. Subsequent medical bills should be mailed promptly to the above address.

CHANGE OF STATUS OPTIONS

Students who waive the Plan for a given semester are eligible to apply for coverage for themselves and their dependents during that semester if they experience a termination of their current medical coverage that is beyond their control. Contact University Health Service for further details at 216-368-3050. Students and dependents must apply for coverage with the Case Student Medical Plan within 30 days of loss of coverage from their current medical insurance.

REFUND POLICY

After enrollment in the Optional Dependent Plan, no portion of the fee is refundable.

APPEAL PROCESS / DENIAL OF BENEFITS

If the participant believes a claim was improperly settled, please complete the following process:

1. Within 60 days of receipt of the claim, the participant may request, in writing, that the plan administrator conduct a review of the processed claim. The plan administrator will review the processed claim and inform the participant whether or not an error was made.
2. If the participant is not satisfied with the above review, a written request for a second review may be submitted to the plan administrator within 60 days of the first review. The request should state, in clear and concise terms, the reason for disagreement with the way the claim was processed. When the written request is received, the claim will be reviewed again and the results of this review furnished in writing to the participant within 60 days in most cases, but no longer than 120 days.

All requests for review of denied claims should include a copy of the initial denial letter and any other pertinent information. Send all information to:

Aetna Student Health
P.O. Box 15708
Boston, MA 02215-0014
877-850-6038

EXCLUSIONS

This list is only a partial list. Please refer to the School's Master Policy on file at the school for a complete list of exclusions.

1. Expenses for or in connection with a Pre-Existing Condition (as defined on page 3). This exclusion does not apply to: a) 13 visits per Plan Year for outpatient mental/nervous and alcohol/substance abuse expenses; b) the first \$2,000 of benefits per Plan Year for inpatient mental/nervous and alcohol/ substance abuse expenses; and c) the first \$1,000 of benefits per Plan Year for any other covered Condition.
2. Expenses incurred in connection with routine exams, or other care, treatment services and supplies which are not medically necessary for the treatment of a Disability, including those which are not consistent with the diagnosed Sickness or Injury.
3. Expenses incurred for or in connection with diagnosis, care and treatment of a mental/nervous condition or alcohol/substance abuse, except as specifically provided.
4. Care, treatment, services or supplies rendered in connection with cosmetic procedures, unless needed because of a covered Injury or Sickness.
5. Expenses incurred in connection with Injuries resulting from an accident involving a motor vehicle, to the extent benefits are payable under any other insurance policy or plan of benefits, unless those benefits are paid only as a result of litigation.
6. Expenses in connection with treatment directly to or on the teeth or gums, except as specifically included and when needed due to Injury to sound natural teeth.
7. Organ or tissue transplant procedures, unless pre-approved by the Plan.
8. Expenses incurred in connection with Injury or Sickness which arises out of or in the course of any occupation or employment, for which the covered participant is entitled to benefits under any Workers' Compensation or similar law.
9. Biofeedback and other forms of self-care or self-help training and any related diagnostic testing.
10. Care which is not recommended and approved by a Physician.
11. Expenses for or in connection with procedures intended solely to increase or enhance fertility; artificial insemination, in-vitro fertilization or similar procedures; reversals of previous sterilization procedures; transsexual surgery; or surrogacy.
12. Treatment of obesity.
13. Injuries resulting from air travel except when traveling as a passenger on a regularly scheduled commercial air flight.
14. Custodial Care: for example, help with walking, bathing, preparing meals, and other activities of daily living.
15. Expenses incurred, to the extent that they exceed the usual, customary and reasonable charge.
16. Services or supplies which are experimental or investigational in nature.
17. Hearing aids or examinations for the prescription and fitting.
18. Injury sustained or Sickness contracted as a result of committing or attempting to commit a felony, or being engaged in an illegal occupation.
19. Services rendered by a person who is an immediate relative of or who ordinarily resides with the covered student requiring treatment.
20. Services or supplies rendered or furnished to a covered participant while in the active military service of any country.
21. Expenses incurred when no coverage is in force for the person incurring charges.
22. Expenses which the covered participant has no legal obligation to pay or for which no charge would be made if he had no coverage.
23. Travel, even though prescribed by a Physician.
24. Services or supplies rendered or furnished in a Military or Veterans Administration Hospital, unless rendered in connection with a Disability which is not in any way related to the covered participant's military service.
25. Injury or Sickness caused by war or any act of war, whether declared or undeclared.

2008-2009 DEPENDENT ENROLLMENT FORM

Deadline for Fall Semester enrollment is September 12, 2008. Deadline for Spring/Summer Semesters enrollment is January 23, 2009. Deadline for Summer only enrollment is June 11, 2009

Contact University Health Service for the Payment Plan Option.

Student's Name _____ Student ID# _____
(Please Print) (First) (Middle) (Last)

Address _____
(Street) (City) (State) (Zip Code)

I have purchased Case Western Reserve University Student Medical Plan; I wish to enroll the following members of my family in the Dependent Medical Plan sponsored by Case Western Reserve University.

Eligible dependents of the covered student shall include the spouse or domestic partner and dependent child/ren under the age of 19 years (all eligible dependents must be residing with the covered Student).

	Annual Cost 8/1/08-7/31/09	Fall '08 8/1/08-1/11/09	Spring & Summer 2009 1/12/09-7/31/09	Summer 2009 Only* 6/1/09-7/31/09
Spouse/Domestic Partner Only	\$2,513.00	\$1,047.00	\$1,465.00	\$519.00
Spouse or Domestic Partner/ Child/ren	\$4,642.00	\$1,935.00	\$2,707.00	\$962.00
Child/ren Only	\$2,124.00	\$887.00	\$1,243.00	\$441.00

NOTE: Return this enrollment form and automatic payment plan form or appropriate check, money order (made payable to Case Western Reserve University) to University Health Service, 2145 Adelbert Rd., Cleveland, OH 44106-4901.

Coverage becomes effective August 1, 2008 or the date the payment is received, whichever is later. Deadline for enrollment is September 12, 2008 for Fall Semester, January 23, 2009 for Spring/Summer Semesters and June 11, 2009 for Summer Semester only.

Medical coverage for spouse/domestic partner and dependent child/ren may not be purchased unless medical coverage for Student is purchased. Students purchasing dependent coverage for Fall Semester only must submit another enrollment form to renew coverage for Spring/Summer Semesters. In order to maintain continuous coverage payment must be received prior to January 23, 2009.

Only students registered for classes for Summer Semester 2009 who were not registered for classes Spring Semester 2009 are eligible to enroll their dependents in the Summer Semester 2009.

Place Dependent Name(s) Below

1) _____ Birth Date _____ M/F

Spouse/Domestic Partner (circle one)

2) _____ Birth Date _____ M/F

Child

3) _____ Birth Date _____ M/F

Child

4) _____ Birth Date _____ M/F

Child

Domestic Partner Enrollment Forms are available at University Health Service.



2008-2009 DEPENDENT ENROLLMENT FORM

(For Students of Case Western Reserve University School of Medicine, the Cleveland Clinic Lerner College of Medicine, and Case Western Reserve University School of Dental Medicine - MSD Program)

Deadline for Fall Semester Enrollment is September 3, 2008. Deadline for Spring/Summer Semesters Enrollment is January 23, 2009.

Contact University Health Service for the Payment Plan Option.

Student's Name _____ Student ID # _____
(Please Print) (First) (Middle) (Last)

Address _____
(Street) (City) (State) (Zip Code)

I have purchased Case Western Reserve University Student Medical Plan, I wish to enroll the following members of my family in the Dependent Medical Plan sponsored by Case Western Reserve University.

Eligible dependents of the covered student shall include the spouse or domestic partner and dependent child/ren under the age of 19 years (all eligible dependents must be residing with the covered Student).

	Annual Cost 7/1/08-6/30/09	Fall '08 7/1/08-1/11/09	Spring & Summer 2009 1/12/09-6/30/09
Spouse/Domestic Partner Only	\$2,513.00	\$1,465.00	\$1,047.00
Spouse or Domestic Partner/Child/ren	\$4,642.00	\$2,707.00	\$1,935.00
Child/ren Only	\$2,124.00	\$1,243.00	\$887.00

NOTE: Return this enrollment form and automatic payment plan form or appropriate check, money order (made payable to Case Western Reserve University) to University Health Service, 2145 Adelbert Rd., Cleveland, OH 44106-4901.

Coverage becomes effective July 1, 2008 or the date the payment is received, whichever is later. Deadline for enrollment is September 3, 2008 for Fall Semester, January 23, 2009 for Spring/Summer Semesters.

Medical coverage for spouse/domestic partner and dependent child/ren may not be purchased unless medical coverage for Student is purchased. Students purchasing dependent coverage for Fall Semester only must submit another enrollment form to renew coverage for Spring/Summer Semesters. In order to maintain continuous coverage payment must be received prior to January 23, 2009.

Place Dependent Name(s) Below

1) _____ Birth Date _____ M/F
Spouse/Domestic Partner (circle one)

2) _____ Birth Date _____ M/F
Child

3) _____ Birth Date _____ M/F
Child

4) _____ Birth Date _____ M/F
Child

Domestic Partner Enrollment Forms are available at University Health Service.