COMPANION LIFE INSURANCE COMPANY
7909 PARKLANE ROAD, SUITE 200, COLUMBIA, SC 29223-5666
P.O. BOX 100102, COLUMBIA, SC 29202-3102
(803) 735-1251
(the "Company")

POLICYHOLDER: New England Culinary Institute
POLICY NO.: 2016I5A68 ("the Policy")
EFFECTIVE DATE: July 1, 2016
POLICY TERM: July 1, 2016 to June 30, 2017
PREMIUM DUE DATE: On or before the Policy Effective Date

READ YOUR POLICY CAREFULLY: This Policy is a legally binding contract between the Insured and Companion Life Insurance Company ("Company" or "Insurer"). The consideration for this Policy includes, but is not limited to, the Application and the payment of premiums as provided for herein. It is governed by the laws of the state in which it is issued.

The Company will pay the insurance benefits provided in this Policy. Payment is subject to the conditions, limitations and exceptions of this Policy.

The Insured agrees to pay premiums when due and to comply with the Policy provisions.

The sections set forth on the following pages are a part of this Policy and take effect on the Effective Date. All periods indicated in the Policy begin and end at 12:01 a.m. Standard Time at the Insured's principal place of business.

IN WITNESS WHEREOF the Companion Life Insurance Company has caused this Policy to be executed by its President at Columbia, South Carolina.

Trescott N. Hinton, Jr.
President

INDIVIDUAL MAJOR MEDICAL INSURANCE POLICY
COVERING ELIGIBLE STUDENTS AT A COLLEGE OR UNIVERSITY
PLEASE READ THIS POLICY CAREFULLY
IMPORTANT NOTICE

Companion Life Insurance Company (the “Insurer” or “Company”) may be contacted at the following address:

Companion Life Insurance Company
7909 Parklane Road, Suite 200
Columbia, SC  29223-5666

or by calling the toll free number shown on your ID card.

The policy is subject to the laws of Vermont. The Vermont Department of Financial Regulation may be contacted at the following address:

State of Vermont
Department of Financial Regulation
89 Main Street, Drawer 20
Montpelier, Vermont  05620-3101

WARNING, LIMITED BENEFITS WILL BE PAID WHEN NON-PARTICIPATING PROVIDERS ARE USED.

Please be aware that when an election is made to utilize the services of a non-participating provider for a covered service in non-emergency situations, benefit payments to such non-participating provider are not based upon the amount billed. The basis of benefit payment will be determined according to the policy's fee schedule, usual and customary charge (which is determined by comparing charges for similar services adjusted to the geographical area where the services are performed), or other method as defined by the policy.

Out-of-network emergency services will be covered the same as in-network emergency services.

EXPECT TO PAY MORE THAN THE COINSURANCE AMOUNT DEFINED IN THE POLICY AFTER THE PLAN HAS PAID ITS REQUIRED PORTION.

Non-participating providers may bill for any amount up to the billed charge after the plan has paid its portion of the bill. Participating providers have agreed to accept discounted payments for services with no additional billing other than co-insurance and deductible amounts. Further information about the participating status of professional providers and information on out-of-pocket expenses may be obtained by calling the toll free telephone number on the identification card.
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SCHEDULE OF BENEFITS

CLASSES OF ELIGIBLE PERSONS:

Class I: All matriculated students.
Dependents of Class I Insureds are eligible for coverage under this Policy.
Students must actively attend classes for at least 25 of the first 31 consecutive days after the date for which coverage is purchased.
A person may not be insured as a Dependent and an Insured at the same time.

MEDICAL EXPENSE BENEFITS

Scope of Coverage:
Benefits will be paid up to the Benefit Maximums shown for each service shown in the schedule below.

Deductible (In-Network and Out-of-Network Combined):

Per Person per policy year: $400.00

Annual Out-of-Pocket Maximum per Covered Person Services Rendered by a Preferred Provider (not including prescription drugs) (In-Network and Out-of-Network Combined):

Per Covered Person $5,550.00
Per Family $11,100.00

Prescription Drug Out-of-Pocket Maximum:

Per Covered Person $1,300.00
Per Family $2,600.00
### HEALTH SERVICES

#### Covered Inpatient Expenses:

<table>
<thead>
<tr>
<th>Inpatient Expense</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room &amp; Board – Limited to the semiprivate room rate</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Hospital Miscellaneous</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Intensive Care</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Surgery</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Fees</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Provider’s Visit (for injury or sickness)</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Emergency Room Care – Medical Emergency only subject to a $100 copayment</td>
<td>80% Preferred Allowance</td>
<td>80% Preferred Allowance</td>
</tr>
<tr>
<td>Mental Health, Alcohol or Substance Abuse</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
</tbody>
</table>

#### Covered Outpatient Expenses:

<table>
<thead>
<tr>
<th>Inpatient Expense</th>
<th>Preferred Provider</th>
<th>Out-of-Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider’s Visits (other than when related to surgery or physiotherapy); subject to a $25 copayment</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Specialist Visits</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Naturopathic Physicians subject to a $25 copayment</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Licensed Athletic Trainers – limited to one visit per day</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Day Surgery including day surgery miscellaneous expenses</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Anesthetist &amp; Assistant Surgeon Fees</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Physiotherapy/Occupational Therapy – limited to one visit per day.</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>HEALTH SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Outpatient Expenses: (continued)</td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>Chiropractor care – limited to one visit per day and subject to a $25 copayment</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Diagnostic X-ray</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Mental Health, Alcohol or Substance Abuse</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Radiation Therapy and Chemotherapy</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Hospice – by a licensed agency/provider for terminally ill patients with life expectancy of 6 months or less – limited to 100 hours per month</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Other Covered Expenses:</td>
<td>Preferred Provider</td>
<td>Out-of-Network Provider</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% U&amp;C</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>80% U&amp;C</td>
<td>80% U&amp;C</td>
</tr>
<tr>
<td>Consulting Provider Fees – When requested and approved by the attending Provider.</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
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<tr>
<td>Maternity (including midwifery services)</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
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<tr>
<td>Complications of Pregnancy</td>
<td>Payable as any other Sickness</td>
<td>Payable as any other Sickness</td>
</tr>
<tr>
<td>Elective Abortion not to exceed a maximum of $750 per policy year.</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
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<tr>
<td>Pediatric Dental Care (except for Preventive Care Items and Services)</td>
<td>80% U&amp;C</td>
<td>60% U&amp;C</td>
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<tr>
<td>Physical Exams, Adult Immunizations or Well Man Exam (except for Preventive Care Items and Services)</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Preventive Care Items and Services, in accordance with section 2713 of the Public Health Service Act</td>
<td>100%</td>
<td>60% U&amp;C</td>
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HEALTH SERVICES

<table>
<thead>
<tr>
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<th>Out-of-Network Provider</th>
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<tr>
<td>Prostate Cancer Screening</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Diabetes – Includes all Medically Necessary equipment, supplies, medications, labs and outpatient self-management training and educational services (except for Preventive Care Items and Services).</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Clinical Trials Benefit</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Dental Anesthesia and Facility – Facility charges and general anesthesia services performed in connection with dental services.</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Early Childhood Development Disorders Benefit</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Inherited Metabolic Diseases Benefit</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Craniofacial Disorders Benefit</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>Prescription Drug Expense Benefit*</td>
<td>100% after a:</td>
<td>60% U&amp;C</td>
</tr>
<tr>
<td>- Only a 30 day supply can be dispensed at any time</td>
<td>$15 Co-pay for Generic Drug</td>
<td></td>
</tr>
<tr>
<td>- One copayment per 30 day supply; copay does not apply to generic contraceptives</td>
<td>$30 Co-pay for Preferred Brand</td>
<td></td>
</tr>
<tr>
<td>- Copayments apply to the out-of-pocket</td>
<td>$50 Co-pay for Non-Preferred Brand</td>
<td></td>
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<tr>
<td>*Exceptions may be made based on whether a drug is generic/preferred/non-preferred/specialty if a Provider certifies that a cheaper alternative is not effective.</td>
<td>$50 Co-pay for Specialty Drug</td>
<td></td>
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<tr>
<td>Off-Label Prescription Drug Benefit</td>
<td>Same as Prescription Drug Expense</td>
<td>Same as Prescription Drug Expense</td>
</tr>
<tr>
<td>Telemedicine Services Benefit</td>
<td>80% Preferred Allowance</td>
<td>60% U&amp;C</td>
</tr>
</tbody>
</table>

Student Health Center Benefit

Covered medical expenses for services received at the University Health Service (UHS) 100%
DEFINITIONS

"Accident" means an unexpected and unintended event, which is the direct cause of an Injury. The Accident must occur while the Covered Person is insured under the Policy.

"Adverse Benefit Determination" means a denial, reduction, modification or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an Insured’s or Dependent’s eligibility, and including a denial, reduction, modification or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. An Adverse Benefit Determination includes a rescission of coverage.

"Allowable Charge" means the charge which is the lesser of: 1) The actual charge, 2) the negotiated charge that a Preferred Provider has agreed to accept for service, or 3) the Usual and Customary Charge for a covered service.

“Ambulatory Surgical Center” means a facility or portion of a facility that provides surgical care not requiring an overnight stay. The office of a dentist in which activities are limited to dentistry and oral or maxillofacial surgical procedures shall not be deemed an ambulatory surgical center for purposes of this section. In order to be considered an ambulatory surgical center, a facility shall meet the following criteria:

1. Charge, or intend to charge, a facility fee in addition to professional fees for the services performed.
2. Have an operating room or recovery room in the facility.
3. Use an anesthesiologist or nurse anesthetist.
4. Provide one or more outpatient services for which Medicare coverage is provided.

“Anesthesiologist” means a person who is licensed to practice medicine or osteopathy in the State of Vermont and who either:

1. Has completed a residency in anesthesiology approved by the American Board of Anesthesiology or the American Osteopathic Board of Anesthesiology or other predecessors or successors; or
2. Is credentialed by a hospital to practice anesthesiology and engages in the practice of anesthesiology at that hospital full-time.

"Benefit Period" means a period commencing on the first date of treatment for a covered Accident or covered Sickness and continuing for a maximum period shown in the Schedule of Benefits. The term, Benefit Period includes any Extension of Benefits shown in the Policy.

“Certified Registered Nurse Anesthetist” means an advanced practice registered nurse licensed by the Vermont Board of Nursing to practice as a certified registered nurse anesthetist.

"Complications of Pregnancy" means conditions which require medical treatment before pregnancy ends, and whose diagnosis is distinct from, but are caused or affected by pregnancy. Such conditions are; acute nephritis or nephrosis, cardiac decompensation; missed abortion; hyperemesis gravidarum; pre-eclampsia; non-elective cesarean section; termination of ectopic pregnancy; and spontaneous termination when a live birth is not possible.
Complications of Pregnancy does not include: false labor; occasional spotting; voluntary abortion; Provider prescribed rest during pregnancy; morning sickness; and similar conditions not medically distinct from a difficult pregnancy.

"Co-payment" means a fixed dollar amount that the Covered Person must pay before benefits are payable under the Policy.

"Covered Accident" means an Accident that occurs while coverage is in force for a Covered Person and results in a loss or Injury covered by the Policy for which benefits are payable.

"Covered Expenses" means expenses actually incurred by or on behalf of a Covered Person for treatment, services and supplies not excluded or limited by the Policy. Coverage under the Policy must remain continuously in force from the date the Accident or Sickness occurs until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

"Covered Person" means any eligible person or an eligible Dependent who applies for coverage, and for whom the required premium is paid to Us.

"Deductible" means the dollar amount of Covered Expenses that must be incurred as an out-of-pocket expense by a Covered Person or per Family on a Policy Term basis before benefits are payable under the Policy.

If two or more Immediate Family Members are Injured in the same Covered Accident, only one deductible will apply.

"Dependent" means: 1) an Insured's lawful spouse; or 2) an Insured's child, from the moment of birth to age 26.

A "child", includes an Insured's: 1) natural child; 2) stepchild; 3) adopted child, and 4) a child placed for adoption.

Coverage will continue for an unmarried child 26 years old or older who is incapable of self-sustaining employment by reason of a mental or physical disability that has been found to be a disability that qualifies or would qualify the child for benefits using the definitions, standards, and methodology in 20 C.F.R. Part 404, Subpart P; who became so incapable prior to attainment of the limiting age; and who is chiefly dependent upon the Insured for support and maintenance. Such a Dependent must be enrolled as such within 60 days after the Dependent’s 26th birthday, with enrollees to be covered retroactively if necessary. If an Insured misses the 60-day enrollment deadline, the incapacitated Dependent may be re-enrolled upon the next renewal date or open enrollment period, as applicable. Proof of the child's condition and dependence will be requested by Us within 2 months prior to the date the child will cease to qualify as a child as defined above. Such proof must be submitted to Us within 31 days from the date of the request. We may, at reasonable intervals thereafter, but not more frequently than once every year, require proof of the continuation of such condition and dependence. If proof is not submitted within the 31 days following any such request, coverage for the Dependent will terminate.

With respect to a child, “dependent on other care providers” means such child requires a Community Integrated Living Arrangement, group home, supervised apartment, or other residential services licensed or certified by the Department of Human Services, the Department of Public Health, or the Department of Public Aid.
The term “spouse” also includes your domestic partner. You and your domestic partner must submit a complete domestic partner affidavit and meet the following criteria to qualify your domestic partner for insurance under this policy. For at least six consecutive months prior to the effective date of your domestic partner insurance, you and your domestic partner:

1. are and have been each other’s sole domestic partner, and have maintained the same principal place of residence and intend to do so indefinitely;
2. are both at least 18 years of age;
3. are not married or related by blood; and
4. are jointly responsible for each other's welfare and financial obligations.

The term also includes the child of your domestic partner.

"Elective Surgery or Elective Treatment" means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that:

1. are deemed by the Insurer to be research, investigative, or experimental;
2. are not generally recognized and accepted medical practices in the United States.

"Emergency Hospitalization" and "Emergency Medical Care" means health care services provided to treat an Emergency Medical Condition.

“Emergency Medical Condition”, means the sudden and, at the time, unexpected onset of an illness or medical condition manifesting itself by symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

“Emergency Services” means health care items and services furnished or required to evaluate and treat an emergency medical condition. Emergency Services include the following:

1. A medical screening examination (as required under Section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and
2. Such further medical examination and treatment, to the extent they are within the capability of the staff and facilities available at the hospital, as are required under Section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(e)).

“Essential Health Benefits” includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
"Experimental or Investigational" means any procedure, treatment, facility, supply, device, or drug that:

1. is not generally accepted by the United States medical community as effective for diagnosis, care or treatment; or
2. is subject to research protocols indicating that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational;" or
3. requires the patient to sign a consent form which indicates that the procedure, treatment, supply, device, or drug is "experimental or investigational;" or
4. requires the provider's institutional review board to acknowledge that the procedure, treatment, facility, supply, device, or drug is "experimental or investigational," and subject to the board's approval.

Important Notice - The Insurer may rely upon the advice of medical and dental peer review groups and other medical and dental experts to determine which services and/or supplies are experimental or investigational. The decision whether there is enough scientific data, and the decision whether a service or supply is "experimental or investigational" will be made by the Insurer.

The Insurer will determine whether a procedure, treatment, facility, supply, device, or drug is "experimental or investigational."

"Home Health Care" means nursing care and treatment and Daily Living Services provided to a Covered Person in His home as part of an overall extended treatment plan. To qualify for Home Health Care Benefits:

1. the Home Health Care plan must be established and approved in writing by a Covered Person's attending doctor, including certification in writing by the attending Provider that confinement in a Hospital or skilled nursing facility would be required in the absence of Home Health Care;
2. nursing care and treatment must be provided by a Hospital certified to provide Home Health Care services or by a certified Home Health Care agency; and

"Daily Living Services" means cooking, feeding, bathing, dressing and personal hygiene services performed by a Home Health Aide, and which are necessary to the care and health of the Covered Person.

"Hospice" means a public or private agency or facility which:

1. administers medically supervised written plans of physical, psychological, social and spiritual care for terminally ill individuals and their immediate family;
2. has its own staff doctors, nurses and medical and social counseling services on call 24 hours a day, 7 days a week or contracts and monitors this staff if not furnished by the hospice itself;
3. is supervised on a full-time basis by a doctor or registered nurse (RN);
4. keeps a written record of all hospice services furnished to its patients and families;
5. makes use of trained volunteers and keeps written records of their use and cost savings;
6. is licensed or certified according to the laws of the state in which it is located; and
7. provides bereavement and medical social services.

"Hospital" means an institution that:

1. is operated pursuant to law;
2. is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the hospital on a pre-arranged basis and under the supervision of a staff of duly licensed physicians, medical, diagnostic and major surgical facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
3. provides 24 hour nursing service by or under the supervision of registered graduate professional nurses (R.N.’s).

Hospital also means a licensed alcohol and drug abuse rehabilitation facility or a mental hospital. Alcohol and drug abuse rehabilitation facilities and mental hospitals are not required to provide organized facilities for major surgery on the premises on a prearranged basis.

"Hospital Confined" means a stay of 18 or more consecutive hours as a registered resident bed-patient in a Hospital. One period of confinement means consecutive days of in hospital service received as an inpatient, or successive confinements when discharge from and readmission to the hospital for the treatment of the same or related condition occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days.

"Immediate Family" means a Covered Person's parent, spouse, child, brother or sister.

“Injury” means accidental bodily harm sustained by a Covered Person that results directly and independently of disease and any bodily infirmity from a Covered Accident. All injuries sustained by one person in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single Injury.

"Insured" means a person in a Class of Eligible Persons who enrolls for coverage and for whom the required premium is paid making insurance in effect for that person. An Insured is not a Dependent covered under the Policy.

“Insurer” means the Companion Life Insurance Company.

“Licensed Mental Health Professional” means a licensed physician, psychologist, social worker, mental health counselor, or nurse with professional training, experience, and demonstrated competence in the treatment of a mental condition or psychiatric disability.

Medically Necessary" means health care services, including diagnostic testing, treatments, drugs, preventive services and aftercare, that are appropriate in terms of type, amount, frequency, level, setting, and duration to the Insured’s diagnosis or condition. Medically-necessary care must be informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition; must be informed by the unique needs of each individual patient and each presenting situation; and

1. help restore or maintain the member’s health; or
2. prevent deterioration of or palliate the member’s condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem

A service, drug or supply will not be considered as Medically Necessary if, it:

1. is investigational, experimental or for research purposes;
2. exceeds in scope, duration or intensity the level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
3. could have been omitted without adversely affecting the person's condition or the quality of medical care; or
4. involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration.
“Medically appropriate off-label use of a drug” means the use of a drug, pursuant to a valid prescription by a health care provider, for other than the particular condition(s) for which approval was given by the U.S. Food and Drug Administration in circumstances in which the medically appropriate off-label use is reasonably calculated to restore or maintain the member’s health, prevent deterioration of or palliate the member’s condition, prevent the reasonably likely onset of a health problem or detect an incipient problem; and that is informed by generally accepted medical or scientific evidence and consistent with generally accepted practice parameters as recognized by health care professions in the same specialties as typically provide the procedure or treatment, or diagnose or manage the medical condition.

“Mental Condition” means any condition or disorder involving psychiatric disabilities or alcohol or substance abuse that falls under any of the diagnostic categories listed in the mental disorders section of the international classification of diseases, as periodically revised.

"Out-of-Network" means a provider who has not entered into a contract with the Insurer. We will not pay charges in excess of the Usual and Customary Charges for Out-of-Network benefits, unless otherwise provided herein. If Medically Necessary care is required and there is no Preferred Provider available, benefits for an Out-of-Network provider will be payable at the same level as a Preferred Provider.

“Pharmacy Care” means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need for or effectiveness of a medication.

"Preferred Allowance" means the amount a Preferred Provider will accept as payment in full for covered medical expenses.

"Preferred Provider" means licensed health care providers, including, but not limited to, Providers, naturopaths, qualified athletic trainers, chiropractors, midwives, mental health and substance abuse treatment providers, Hospitals and other health care providers, who have contracted with the Insurer to provide specific medical care to Covered Persons in a service area at negotiated prices. A list of Preferred Providers for this policy is available by calling the toll free telephone number on Your identification card.

"Prescription Drugs" mean 1) prescription legend drugs; 2) compound medications of which at least one ingredient is a prescription legend drug; 3) any other drugs that under the applicable state or federal law may be dispensed only upon written prescription of a Provider; and 4) injectable insulin.

"Provider" means any practitioner of the healing arts who is licensed or certified by the state in which his or her services are rendered and acting within the scope of that license or certificate.

It will not include a Covered Person or a member of the Covered Person's Immediate Family or household.

"Sickness" means an illness, disease or condition of the Covered Person that causes a loss for which a Covered Person incurs medical expenses while covered under the Policy. All related conditions and recurrent symptoms of the same or similar condition will be considered one Sickness.

"Usual and Customary Charge" or (“U&C”) means the average amount charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

"We, Our, Us" means Company or its authorized agent.

"You" means each Insured or Dependent, as the context so requires.
ELIGIBILITY FOR INSURANCE

Each person in one of the Classes of Eligible Persons shown in the Schedule of Benefits is eligible to be insured under the Policy. This includes anyone who may become eligible on the Policy Effective Date, and after the Policy Effective Date while the Policy is in force. Home study, correspondence, on-line, and television (TV) courses do not fulfill the eligibility requirements. We maintain the right to investigate student status and attendance records to verify eligibility requirements have been met. If We discover the eligibility requirements have not been met, Our only obligation is to refund any premium paid for that person.

A person may be insured under only one Class of Eligible Persons shown in the Schedule of Benefits, even though the person may be eligible under more than one Class.

An Insured's Dependent is eligible on the date:
1. the Insured is eligible, if the Insured has Dependents on that date; or
2. the date the person becomes a Dependent of the Insured, if later.

Dependent children who are Covered Persons may remain covered under this Policy to age 26.

In no event will a Dependent be eligible if the Insured is not enrolled.

EFFECTIVE DATE OF INSURANCE

Insurance for an Eligible Person who enrolls during the enrollment period established by the school is effective on the latest of the following dates:
1. the Policy Effective Date;
2. the date We receive the completed enrollment form;
3. the date the required premium is paid; or
4. the date the student enters the Eligible Class.

After the open enrollment period established by the school, You must wait until the next enrollment period to enroll, except in the case of the following life events for which You will be eligible for a special enrollment period.

1. You lose coverage under another health care plan that constitutes minimum essential coverage (“MEC”) (unless the loss of MEC is due to (i) a failure to pay any required premiums on a timely basis, or (ii) fraud or an intentional misrepresentation of material fact), or certain non-MEC pregnancy-related or medically needy coverage under Medicaid.
2. You gain or become a Dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support or other court order.
3. You lose a Dependent or are no longer considered a Dependent due to divorce, legal separation, or death.
4. You were previously enrolled in health insurance coverage purchased through a Health Insurance Marketplace established under the Patient Protection and Affordable Care Act, and such enrollment was unintentional, inadvertent or erroneous, and resulted from an error, misrepresentation, misconduct, or inaction of an officer, employee or agent of the Marketplace or the U.S. Department of Health and Human Services, its instrumentalities, or another entity providing enrollment assistance or conducting enrollment activities.
5. You were previously enrolled in other health insurance coverage, and the carrier substantially violated a material provision of the contract.
6. You experience a change in Your eligibility for federal subsidies to purchase health insurance coverage through a Health Insurance Marketplace established under the Patient Protection and Affordable Care Act.

In order to utilize a special enrollment period, You generally will need to elect coverage under this policy within sixty (60) calendar days after the relevant event. However, for a loss of MEC or pregnancy-related or medically needy coverage under Medicaid, you also may elect coverage up to 60 days before the event.

If you elect coverage in advance of the event or loss of coverage, Your coverage will take effect as of the first day of the month following that event or loss of coverage. In the case of marriage, Your coverage will take effect as of the first day of the month following your enrollment in this policy. For a birth, adoption, placement for adoption, or placement in foster care, Your coverage will take effect as of the date of the event (which generally will be retroactively), provided that You may choose instead to have the coverage become effective either (i) as of the first of the month following the date of the event, or (ii) in accordance with the standard effective dates described below. For a court order, Your coverage will take effect on the date the court order is effective, provided that You may choose instead to have the coverage become effective in accordance with the standard effective dates described below.

The standard effective dates, in all other cases, are as follows: (i) if You elect coverage between the first and fifteenth day of a given month, Your coverage will take effect as of the first day of the following month, and (ii) if You elect coverage between the sixteenth and last day of a given month, Your coverage generally will take effect as of the first day of the second following month.

We will pay benefits for a newborn child of the Insured for sixty (60) days after the date of birth. Coverage may be continued beyond 60 days if the Insured notifies Us of the child’s birth and pays the required premium, if any.

Adopted children will be covered on the same basis as a newborn child from the date the child is placed for adoption with the Insured regardless of whether the adoption has become final. Coverage will cease on the date the child is removed from placement for adoption with You. An adopted child is one who has not yet attained 18 years of age.

Coverage for newborn and adopted children will consist of coverage for covered Injury, covered Sickness, necessary care, and treatment of medically diagnosed congenital defect or birth abnormality, or any combination of these, and shall include, but not be limited to, prematurity, well born care, birth abnormalities, and routine nursery care related with a covered Sickness.

As used in this section:

"Placed for adoption" means circumstances under which the Insured assumes or retains a legal obligation to partially or totally support a child in anticipation of the child's adoption. A placement ends at the time such legal obligation ends.

**TERMINATION**

**TERMINATION DATE OF INSURANCE**

An Insured’s coverage will end on the earliest of the date:
1. the Policy terminates;
2. the Insured is no longer eligible; or
3. the period ends for which premium is paid, subject to the Policy Grace Period provision.
A Dependent's coverage will end on the earliest of the date:
1. he or she is no longer a Dependent;
2. the Insured's coverage ends;
3. the period ends for which premium is paid, subject to the Policy Grace Period provision; or
4. the Policy terminates.

REFUND OF PREMIUM

Except in the event of a certified medical leave of absence, if the insured student withdraws from school or reduces his/her semester hours to less than six (6), within the first thirty (30) days of the semester, We will refund any premiums paid for the student and any covered Dependents and coverage will be terminated.

A pro-rata refund of premium will be made only in the event:

1. the Covered Person enters full-time active duty in any Armed Forces; and
2. We receive proof of such active duty service.

EXTENSION OF BENEFITS

If a Covered Person is confined in a Hospital for a medical condition on the date his insurance ends, expenses Incurred during the continuation of that Hospital stay will be considered a Covered Expense, but only while such expenses are incurred during the 90 day period following the termination of insurance. We will not continue to pay these Covered Expenses if:

1. the Covered Person's medical condition no longer continues;
2. the Covered Person obtains other coverage; or
3. the Covered Expenses are incurred more than 3 months following termination of insurance

If a Covered Person is totally disabled on the date of termination of the Policy, We will provide an extension of benefits for 90 days following the termination of insurance.

DESCRIPTION OF BENEFITS

The following provisions explain the benefits available under the Policy. Please see the Schedule of Benefits for the applicability of these benefits on a class level.

We will pay the Covered Expenses as shown in the Schedule of Benefits if a Covered Person requires treatment by a Provider. We will consider the Usual and Customary Charges incurred for Medically Necessary Covered Expenses. Benefit payments are subject to the deductibles, co-insurance factors and benefit maximums, if any, shown in the Schedule of Benefits.

Covered Expenses include:

Inpatient Expenses

1. Hospital Room and Board Expenses: daily semi-private room rate when Hospital Confined as shown in the Schedule of Benefits; and general nursing care provided and charged for by the Hospital.
2. Intensive Care as shown in the Schedule of Benefits. We will make this payment in lieu of the semi-private room expenses.
3. Hospital Miscellaneous Expenses: expenses incurred while Hospital Confined or as a precondition for being Hospital Confined, for services and supplies such as the cost of operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, physical therapy, therapeutic services and supplies. In computing the number of days payable under this benefit, the date of admission will be counted but not the date of discharge.


5. Assistant Surgeon Fees in connection with inpatient surgery as shown in the Schedule of Benefits.

6. Anesthetist Services in connection with inpatient surgery.

7. Provider's Visits when Hospital Confined. This benefit does not apply when related to surgery.

8. Organ Transplant including non-investigative and non-experimental human organs and tissue transplants that are Medically Necessary.

Outpatient Expenses


10. Day Surgery Miscellaneous Expenses: Includes services related to scheduled surgery performed in a Hospital or ambulatory surgical center, facility service fees, operating room expenses, laboratory tests and diagnostic test expenses, examinations, professional fees, anesthesia, drugs or medicines, and therapeutic services and supplies. Not covered under this benefit are surgeries performed in a Hospital emergency room, Provider's office, or clinic.

11. Medically Necessary Anesthetist Services for covered procedures and services.

12. Provider's Visits: Includes well visits and routine gynecological exams; benefits are limited to one visit per day.

13. Naturopathic Physicians: Medically Necessary health care services covered by this policy will be similarly covered when provided by a licensed naturopathic physician acting within the Vermont designated scope of practice. Naturopathic physicians who practice primary care will be recognized as primary care physicians. Health care services provided by naturopathic physicians will be subject to the same deductible, co-payment and co-insurance amounts, as those applicable to other primary care physicians under the plan.

14. Licensed Athletic Trainers benefits are limited to one visit per day. To the extent coverage is provided for a particular type of health service or for any particular medical condition that is within the scope of practice of athletic trainers, a licensed athletic trainer who acts within the scope of practice authorized by Vermont law shall not be denied reimbursement by the Insurer for those covered services if the Insurer would reimburse another Provider for those services.

15. Physical Therapy benefits are limited to one visit per day.

16. Chiropractic Expenses benefits are limited to one visit per day. We will cover clinically necessary health care services provided by a chiropractic physician licensed in this State of Vermont for treatment within the scope of practice, as described under Vermont law, and limited to adjunctive therapies to physiotherapy modalities and rehabilitative exercises. No coverage will be provided for visceral condition arising from problems or dysfunctions of the abdominal or thoracic organs. Health care services provided by chiropractic physicians will be subject to the same deductibles, co-payment and co-insurance amounts as those applicable to the same services provided by other health care providers under this policy. Requirements and conditions that apply to coverage for services by Providers other than chiropractic physicians under this policy also apply to chiropractic physicians.

17. Diagnostic X-ray Services: Includes diagnostic services and medical procedures performed by a Provider.
18. Medical Emergency Expenses benefits will be paid for the use of the emergency room and
supplies in connection with an Emergency Medical Condition. Treatment must be rendered
within 48 hours from time of Injury or first onset of Sickness.

19. Radiation & Chemotherapy, as shown in the Schedule of Benefits, coverage will be provided
for chemotherapy services, including medically-necessary growth cell stimulating factor
injections taken as part of a prescribed chemotherapy regimen. Coverage that is no less
favorable on a financial basis than coverage provided for intravenously administered or
injected anticancer medications will be provided for prescribed, orally administered
anticancer medications used to kill or slow the growth of cancerous cells.

20. Laboratory Procedures as shown in the Schedule of Benefits.

Other Expenses

21. Ambulance Service. Payment will be made to the provider as shown in the Schedule of
Benefits.

22. Braces and Appliances: 1) when prescribed by a Provider; and 2) a written prescription
accompanies the claim when submitted. Replacement braces and appliances are not covered.
Braces and appliances include durable, medical equipment which is equipment that:
   a. is primarily and customarily used to serve a medical purpose;
   b. can withstand repeated use; and
   c. generally is not useful to person in the absence of Injury.
   d. No benefits will be paid for rental charges in excess of the purchase price.

23. Consultant Provider Fees: when requested and approved by the attending Provider. Covered
Expenses will be paid under this benefit or under the Provider's Visits benefit, but not for the
same day.

24. The Insurer will pay the actual expenses incurred by a Covered Person as a result of
pregnancy, childbirth, prenatal care, and related conditions and Complications (“Maternity
Services”). This coverage shall be subject to the same deductibles, durational limits and co-
insurance factors as other conditions, illnesses or accidents covered by this policy. Certain
maternity testing that is not Medically Necessary will not be covered under the Policy. Pre-
natal vitamins, other than folic acid, are not covered.

Use of the delivery room, newborn care and anesthesia services to include services rendered
by an anesthesiologist to provide partial or complete loss of sensation before delivery are
covered. Coverage is also provided for delivery and the hospital delivery facility fee. Maternity
Services will be covered at the same level as for other Providers when rendered by
a midwife licensed under Vermont law or an advanced practice registered nurse licensed
under Vermont law who is certified as a nurse midwife when those services are within the
licensed midwife's or certified nurse midwife's scope of practice. These services will be
covered when provided in a hospital or other health care facility or at home. Coverage for
services provided by a licensed midwife or certified nurse midwife will not be subject to any
greater co-payment, deductible, or coinsurance than is applicable to any other similar benefits
provided by the plan.

Pregnancy benefits will also cover a period of hospitalization for maternity and newborn
infant care for:
   a. a minimum of 48 hours of inpatient care following a vaginal delivery; or
   b. a minimum of 96 hours of inpatient care following delivery by cesarean section.
If the Provider, midwife or advanced practice nurse in consultation with the mother, determines that an early discharge is medically appropriate, the Insurer shall provide coverage for post-delivery care, within the above time limits, to be delivered in the patient's home, or, in a provider's office, as determined by the Provider, midwife or advanced practice nurse in consultation with the mother. The at-home post-delivery care shall be provided by a registered professional nurse, Provider, nurse practitioner, midwife, advanced practice nurse certified as a midwife or physician's assistant experienced in maternal and child health, and shall include:

   a. Parental education;
   b. Assistance and training in breast or bottle feeding; and
   c. Performance of any Medically Necessary and clinically appropriate tests including the collection of an adequate sample for hereditary and metabolic newborn screening.

25. Routine Well-Baby Care: 1) while the baby is Hospital Confined; and 2) for routine nursery care provided immediately after birth, including treatment of diagnosed congenital and birth abnormalities.

26. Hospice Care as shown in the Schedule of Benefits. Hospice services provided by a home health aide for personal care services will be covered up to 100 hours per month. Coverage will be provided for the following hospice services:
   a. Respite care services for 72 hours/month
   b. Social services visits at 6 visits per lifetime
   c. Bereavement visits at 2 visits per lifetime
   d. Homemaker services for 100 hours/month
   e. Continuous care services in home at 5 days per admission or for 120 hours of continuous care.

27. Durable Medical Equipment. Prosthetic Appliances and Medical Services: for Medically Necessary services. Coverage will be provided for prosthetic devices at the same level as coverage provided under Medicare. Coverage will include Medically Necessary repair or replacement of a prosthetic device. Coverage may be limited to the prosthetic device that is the most appropriate model that is Medically Necessary to meet the Covered Person's medical needs. Coverage will not be subject to a deductible, co-payment, or coinsurance in excess of the deductible, co-payment, or coinsurance requirements applied to other non-primary care items and services under this policy.

Emergency Services Prior to Stabilization

Coverage for emergency services as provided under this Policy is not dependent upon whether the services are performed by a Preferred Provider or an out of network provider and without regard to prior authorization. Benefits for the services of an out of network provider, if payable, will be at the same benefit level as if the services or treatment had been rendered by a Preferred Provider.

The medical director's or his or her designee's determination of whether the condition Covered Person has meets the standards of an emergency medical condition shall be based solely upon the presenting symptoms documented in the medical record at the time care was sought. Only a clinical peer may make an adverse determination.
**Mammography Examinations and Pap Smear Test Expense Benefit**

Benefits payable under the policy include coverage for the full cost of mammography services incurred by a Covered Person for mammography examinations for the presence of occult breast cancer.

Benefits payable for routine mammography screenings will be limited to the following schedule:

1. an annual mammography examination for women age 40 and older; and
2. for women less than 40 years of age, coverage for screening will be provided upon recommendation of a Provider.

Benefits are also payable under the policy for expenses incurred by a covered person for annual cervical or Pap Smear test.

As used in this section:

“Mammography” means the x-ray examination of the breast using equipment dedicated specifically for mammography, including the x-ray tube, filter, compression device, screens, films and cassettes.

“Screening” includes the mammography test procedure and a qualified Provider’s interpretation of the results of the procedure, including additional views and interpretation as needed.

**Bone Mass Measurement and Osteoporosis Treatment Expense Benefit**

We will pay covered Expenses incurred by a Covered Person for bone mass measurement, and the diagnosis and treatment of osteoporosis.

**Mental Health, Alcohol and Substance Abuse Benefit**

We will pay the Covered Expenses incurred by a Covered Person for Medically Necessary in-patient and out-patient treatment of Mental Health and Substance Abuse furnished.

Benefit payments for Mental Health and Substance Abuse will be subject to the same Deductible, Coinsurance rate, Benefit Maximum, and Benefit Period as treatment for other health conditions (as shown in the Schedule of Benefits).

For the treatment of mental condition, Insurer will cover services rendered by any mental health professional who is licensed or certified by the state in which services are rendered. Coverage will also be provided for treatment of a mental condition rendered in a mental health facility qualified pursuant to rules adopted by the Secretary of Human Services or in an institution approved by the Secretary of Human Services that provides a program for the treatment of a mental condition pursuant to a written plan. For the treatment of alcohol or substance abuse, Insurer will cover services rendered by any substance abuse counselor or other person approved by the Vermont Secretary of Human Services. Coverage will also be provided for alcohol or substance abuse treatment provided in an institution approved by the Vermont Secretary of Human Services that provides a program for the treatment of alcohol or substance dependency pursuant to a written plan. Insurer will cover outpatient family and couples therapy which is rendered by any mental health professional who is licensed or certified by the state in which services are rendered.
Inpatient Care Following Mastectomy

Inpatient benefits following a mastectomy will be provided for a length of time determined by the attending doctor to be Medically Necessary. The length of time will be based on the evaluation of the patient and the availability of post-discharge doctor's office visit or in-home nurse visit to verify the condition of the patient in the first 48 hours after discharge.

Benefits will be payable on the same basis as any other illness under the Policy.

"Mastectomy" means the surgical removal of all or part of a breast.

Breast Reconstructive Surgery after Mastectomy

The federal Women's Health and Cancer Rights Act requires coverage for certain treatment related to mastectomy. If you are eligible for mastectomy benefits under this Policy and you elect breast reconstruction in connection with such mastectomy, you also are covered for the following:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment for physical complications of all stages of mastectomy, including Lymphedemas.

Coverage for breast reconstructive surgery may not be denied or reduced on the grounds that it is cosmetic in nature or, that it otherwise does not meet the policy definition of "Medically Necessary" or "medically required."

Pediatric Vision Care Benefit

Coverage is provided for children up to age 21 for the following:

1. one routine eye exam per calendar year;
2. one pair of standard eyeglass lenses or contact lenses per year (payable at 100% up to $150, then 60% thereafter);
3. one frame every year; and
4. other required vision services including optional lenses and treatments.

Pediatric Dental Care Benefit

We will pay for the following dental care for Covered Persons and Dependents up to the age of 21:

1. dental checkups (twice a year);
2. cleaning and fluoride treatments (twice a year);
3. diagnosis
4. x-rays
5. simple restoration (fillings);
6. sealants;
7. space maintainers;
8. extractions including wisdom teeth removal;
9. endodontics (root canal treatment);
10. dentures (and replacement);
11. bridges (and replacement);
12. crowns and jackets;
13. repair of crowns; and
14. other medically necessary dental services, to include orthodontia.
Hospitalization and Anesthesia Related to Dental Procedures

We will pay the Covered Expenses incurred for Hospital or Ambulatory Surgical Center services and for general anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist for dental procedures performed on a Covered Person who is:

1. a child who is determined by a licensed dentist to be unable to receive needed dental treatment in an outpatient setting, where the Provider treating the patient certifies that due to the patient’s age and the patient’s condition or problem, hospitalization or general anesthesia in a hospital or ambulatory surgical center is required in order to perform significantly complex dental procedures safely and effectively;
2. a child with documented phobias or a documented mental condition or psychiatric disability, as determined by a licensed physician or a licensed mental health professional, whose dental needs are sufficiently complex and urgent that delaying or deferring treatment can be expected to result in infection, loss of teeth, or other increased oral or dental morbidity, for whom a successful result cannot be expected from dental care provided under local anesthesia; and for whom a superior result can be expected from dental care provided under general anesthesia; or
3. a person who has exceptional medical circumstances or a developmental disability, as determined by a licensed physician which place the person at serious risk.

Prostate Cancer Screening Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for prostate cancer screening consistent with the recommendations by the Centers for Disease Control and Prevention or upon the recommendation of a Provider.

Contraceptive Services / Sterilization

We will pay the Covered Expenses incurred by a Covered Person for outpatient contraceptive services, including sterilizations, as well as one inpatient sterilization reversal procedure per lifetime.

Colorectal Cancer Screening Expense Benefit

We will pay the Covered Expenses incurred by a Covered Person for colorectal cancer screening including:

1. Providing an Insured 50 years of age or older with the option of:
   a. Annual fecal occult blood testing plus one flexible sigmoidoscopy every five years; or
   b. One colonoscopy every 10 years.
2. For an Insured who is at high risk for colorectal cancer, colorectal cancer screening examination and laboratory tests as recommend by the treating physician.

For the purposes of this section, an Insured is at high risk for colorectal cancer if the Insured has:

1. A family medical history of colorectal cancer or a genetic syndrome predisposing the individual to colorectal cancer;
2. A prior occurrence of colorectal cancer or precursor polyps.
3. A prior occurrence of a chronic digestive disease condition such as inflammatory bowel disease, Crohn’s disease, or ulcerative colitis; or
4. Other predisposing factors as determined by the Insured’s treating physician.
Colorectal cancer screening services are not subject to any co-payment, deductible, coinsurance, or other cost-sharing requirements. In addition, an Insured shall not be subject to any additional charge for any services associated with a procedure or test for colorectal cancer screening, which may include one or more of the following:

(1) Removal of tissue or other matter;
(2) Laboratory services;
(3) Physician services;
(4) Facility use; and
(5) Anesthesia.

**Diabetes Coverage**

Benefits will be paid for Covered Expenses incurred by a Covered Person for the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, prescribed by a Preferred Provider for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law.

Benefits for such charges will be payable on the same basis as any other illness under the Policy.

Equipment and related supplies include, but are not limited to, the following:

1. Blood glucose monitors;
2. Blood glucose monitors for the visually impaired;
3. Diabetes data management systems for management of blood glucose;
4. Insulin pumps and equipment for the use of the pump including batteries;
5. Insulin infusion pumps; and
6. Podiatric appliances and therapeutic footwear.

Coverage is also provided for the regular foot care exams of a diabetic patient when provided by a licensed Provider.

**Diabetic Self-Management Education Programs**

Benefits are payable for Covered Expenses incurred for a program of instruction in the self-care of diabetes that enables a diabetic to understand the disease and to manage its daily therapy.

Such a program must be prescribed by a Provider. The program must be taught by a "qualified provider," which means a certified, registered or licensed Preferred Provider with specialized training in the education and management of diabetes.

Coverage includes Medically Necessary visits to a "qualified provider" after the diabetic's Provider has made an initial diagnosis of diabetes and after the diabetic's Provider has determined that a significant change in the diabetic's symptoms or medical condition has occurred. A "significant change" in condition means symptomatic hyperglycemia {greater than 250 mg/dl on repeated occasions}, severe hypoglycemia {requiring the assistance of another person}, onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.
Clinical Trials Benefit

We will pay the Covered Expenses for patient costs incurred during participation in clinical trials for the prevention, detection or treatment of cancer or other life-threatening disease or condition, when the trial is (i) a federally funded or approved trial, (ii) conducted under an investigational new drug application reviewed by the USFDA, or (iii) a drug trial exempt from having an investigational new drug application.

Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial. The treatment must be provided by a clinical trial approved by:

1. The National Institutes of Health (“NIH”);
2. An NIH-affiliated cooperative group that is a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group;
3. The FDA in the form of an investigational new drug application or exemption; or
4. The federal departments of Veterans Affairs or Defense.

Coverage under this section shall only apply if:

1. It is conducted by a cancer care provider as defined in this section;
2. It is conducted by a facility and personnel capable of conducting such a trial by virtue of experience, training and volume of patients treated to maintain expertise;
3. It enrolls only those patients for whom there is no clearly superior, non-investigational treatment alternative to the cancer clinical trial and the available clinical or pre-clinical data provide a reasonable expectation that the treatment obtained in the cancer clinical trial will be at least as effective as the non-investigational alternative; and
4. It is conducted only after obtaining fully informed, written consent from the patient or the patient’s legally authorized representative in a manner that is consistent with current legal and ethical standards and requirements.

For purposes of this section:

“Cancer care provider” means the following: the Vermont Cancer Center at Fletcher Allen Health Care, the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center, and a Vermont hospital and its affiliated, qualified Vermont cancer care providers administering approved cancer clinical trials.

Home Health Care Expense Benefit

We will pay the Covered Expenses incurred for care and treatment rendered to a Person by a Home Health Care Agency for the following Home Health Care Services:

1. Part-time or intermittent skilled nursing care;
2. Physical therapy, occupational therapy, speech therapy and audiology; respiratory and inhalation therapy;
3. Part-time or intermittent home health aide services which consist primarily of caring for the patient;
4. Medical social service by a qualified social worker licensed by the jurisdiction in which services are rendered;
5. Nutrition counseling by a nutritionist or dietician;
6. Home Health Aide services;
7. Medical supplies, drugs and equipment, and laboratory services to the extent that laboratory services would have been covered if the patient had been institutionalized;
8. Any diagnostic and therapeutic service, including surgical services, performed in a Hospital outpatient department, ambulatory surgical facility, Provider's office, or any other licensed health care facility, to the extent such service would have been covered under the Policy if the patient had been institutionalized, and provided that such service is delivered as part of the Home Health Care Plan.

Home Health Care Agency visits are limited to 40 visits in any continuous 12-month period for each Covered Person. Each visit of the home health care agency, other than a home health aide, shall be considered one Home Health Care Agency visit. Services up to 4 hours by a Home Health Agency team will be considered as one Home Health Care Agency visit.

Benefit payments will be subject to a Deductible of $50.00 annually, and a co-insurance rate of not less than 80% of reasonable charges.

For purposes of this section:

"Home Health Aide" means a person who:

1. Provides care of a medical or therapeutic nature, or who provides Daily Living Services; and
2. Reports to and is under the direct supervision of a Home Health Care Agency.

Home Health Agency: means a nonprofit home health agency which has been certified under Title 18 of the Social Security Act (42 USC §1395 et seq.).

Private Duty Nursing

We will provide skilled nursing services by a licensed private duty registered or licensed practical nurse in the home for up to 20 visits per calendar year. Coverage is provided when your Physician approves a plan of treatment for a reasonable period of time, includes a treatment plan in your medical record, certifies that the services are not for custodial care, and re-certifies the treatment plan every 60 days.

Early Childhood Developmental Disorders Benefit

We will provide coverage for the evidence-based diagnosis and treatment of early childhood developmental disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age 26. We will also cover applied behavior analysis when the services are provided or supervised by a licensed provider who is working within the scope of his or her license or who is a nationally board-certified behavior analyst. The amount, frequency, and duration of treatment described in this section shall be based on medical necessity. Coinsurance, co-payment, deductible, and other cost-sharing requirements for coverage of the diagnosis or treatment of early childhood shall be the same as the coinsurance, co-payment, deductible and other cost-sharing requirements for other physical and mental conditions under this policy. Coverage under this section will be provided for services delivered in the natural environment when the services are furnished by a provider working within the scope of his or her license or under the direct supervision of a licensed provider or, for applied behavior analysis, by or under the supervision of a nationally board-certified behavior analyst.

We may require treatment plan reviews for a Covered Person who is receiving treatment for an early developmental delay based on the needs of the individual Covered Person, and consistent with reviews for other diagnostic areas. We will review the treatment plan for children under the age of eight no more frequently than once every six months.
Definitions: As used in this section:

1. “Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior. The term includes the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

2. “Autism spectrum disorders” means one or more pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, pervasive developmental disorder not otherwise specified, and Asperger’s disorder.

3. “Behavioral health treatment” means evidence-based counseling and treatment programs, including applied behavior analysis, that are:
   a. necessary to develop skills and abilities for the maximum reduction of physical or mental disability and for restoration of an individual to his or her best functional level, or to ensure that an individual under the age of 21 achieves proper growth and development;
   b. provided or supervised by a nationally board-certified behavior analyst or by a licensed provider, so long as the services performed are within the provider's scope of practice and certifications.

4. “Diagnosis of early childhood developmental disorders” means medically necessary assessments, evaluations, or tests to determine whether an individual has an early childhood developmental delay, including an autism spectrum disorder.

5. “Early childhood developmental disorder” means a childhood mental or physical impairment or combination of mental and physical impairments that results in functional limitations in major life activities, accompanied by a diagnosis defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Disease (ICD). The term includes autism spectrum disorders, but does not include a learning disability.

6. “Evidence-based” means the same as in 18 V.S.A. § 4621.

7. “Natural environment” means a home or child care setting.

8. “Psychiatric care” means direct or consultative services provided by a licensed physician certified in psychiatry by the American Board of Medical Specialties.

9. “Psychological care” means direct or consultative services provided by a psychologist licensed pursuant to 26 V.S.A. chapter 55.

10. “Therapeutic care” means services provided by licensed or certified speech language pathologists, occupational therapists, or physical therapists.

11. “Treatment for early developmental disorders” means evidence-based care and related equipment prescribed or ordered for an individual by a licensed health care provider or a licensed psychologist who determines the care to be medically necessary, including:
   a. behavioral health treatment;
   b. pharmacy care;
   c. psychiatric care;
   d. psychological care; and
   e. therapeutic care.

Inherited Metabolic Disease Benefit

We will provide coverage for medical foods prescribed for medically necessary treatment for an inherited metabolic disease including coverage for a 12-month supply of the low protein modified food products prescribed for medically necessary treatment of an inherited metabolic disease.

For the purposes of this section:

“Inherited metabolic disease” means a disease caused by an inherited abnormality of body chemistry for which the state screens newborn infants.
“Low protein modified food product” means a food product that is specifically formulated to have less than one gram of protein per serving and is intended to be used under the direction of a physician for the dietary treatment of a metabolic disease.

“Medical food” means an amino acid modified preparation that is intended to be used under the direction of a physician for the dietary treatment of an inherited metabolic disease.

**Craniofacial Disorders Benefit**

We will provide coverage for diagnosis and medically necessary treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage shall be the same as that provided under the policy for any other musculoskeletal disorder in the body and may be provided when prescribed or administered by a physician or a dentist. This benefit does not provide coverage for dental services for the diagnosis or treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

**Prescription Drug Coverage**

Company, and any contracted pharmacy benefit manager doing business in Vermont, if applicable, will permit a licensed retail pharmacist to fill prescriptions in the same manner and at the same level of reimbursement as they are filled by mail order pharmacies with respect to the quantity of drugs or days’ supply of drugs dispensed under each prescription.

Coverage will be provided for prescription drugs purchased in Canada, and used in Canada or reimported legally or purchased through the I-SaveRx program on the same benefit terms and conditions as prescription drugs purchased in the United States. For drugs purchased by mail or through the Internet, accreditation by the Internet and Mail-Order Pharmacy Accreditation Commission (IMPAC/tm) or similar organization is required.

As used in this section:

“Pharmacy benefit manager” means an entity that performs pharmacy benefit management.

“Pharmacy benefit management” means an arrangement for the procurement of prescription drugs at negotiated dispensing rates, the administration or management of prescription drug benefits provided by a health insurance plan for the benefit of beneficiaries, or any of the following services provided with regard to the administration of pharmacy benefits:

(a) Mail service pharmacy;
(b) Claims processing, retail network management, and payment of claims to pharmacies for prescription drugs dispensed to beneficiaries;
(c) Clinical formulary development and management services;
(d) Rebate contracting and administration;
(e) Certain patient compliance, therapeutic intervention, and generic substitution programs; and
(f) Disease management programs.

For an up-to-date, accurate, and complete list of all covered Prescription Drugs, please visit [www.optumrx.com](http://www.optumrx.com).
You, your designee, or your prescribing physician (or other prescriber, as appropriate) may request an exception to gain access to any clinically appropriate Prescription Drugs not otherwise covered by this policy. There are two types of exception requests: standard and expedited. You will be eligible for an expedited exception request if you are suffering from a health condition that may seriously jeopardize your life, health, or ability to regain maximum function, or are undergoing a current course of treatment using a Prescription Drug that is not covered by this policy. In all other cases, you will be eligible for a standard exception request.

You may submit a standard exception request by contacting Optum at 1-800-248-1062. You (and/or your designee, prescribing physician, or other prescriber, as applicable) will be notified of the determination on your standard exception request within 72 hours following receipt of the request. If your exception request is granted, the Prescription Drug at issue will be treated as covered under this policy for the duration of the prescription, including refills.

You may submit an expedited exception request by contacting Optum at 1-800-248-1062. You (and/or your designee, prescribing physician, or other prescriber, as applicable) will be notified of the determination on your expedited exception request within 24 hours following receipt of the request. If your exception request is granted, the Prescription Drug at issue will be treated as covered under this policy for the duration of the condition or circumstances (“exigency”) giving rise to the expedited exception request.

If your exception request is denied, you, your designee, or your prescribing physician (or other prescriber, as appropriate) may request an external exception review by an independent review organization by contacting Optum at 1-800-248-1062. You (and/or your designee, prescribing physician, or other prescriber, as applicable) will be notified of the determination on your external exception review within (i) 72 hours following receipt of the request, if the original exception request was a standard exception request, or (ii) 24 hours following receipt of the request, if the original exception request was an expedited exception request. If your external exception review request is granted, the Prescription Drug at issue will be treated as covered under this policy (i) for the duration of the prescription, including refills, if the original exception request was a standard exception request, or (ii) for the duration of the exigency, if the original exception request was an expedited exception request.

An exception will be granted to a Pharmacy Benefit Management program requirement and shall provide coverage on the same terms as it would have for the Pharmacy Benefit Management program if the Insured’s prescribing health care provider certifies, based on relevant clinical information about the particular Insured and sound medical or scientific evidence or the known characteristics of the drug, that the Pharmacy Benefit Management program requirement:

1. Has been ineffective or is reasonably expected to be ineffective or significantly less effective in treating this member’s condition such that an exception is medically necessary; or
2. Has caused or is reasonably expected to cause adverse or harmful reactions in this Insured.

Infertility drugs (four months of fertility medication per plan year when attempting to conceive through natural means) are covered under this Policy.

The out-of-pocket maximum amounts payable for Prescription Drugs are shown on the Schedule of Benefits.
Off-Label Prescription Drug Benefit

Coverage for prescription drugs will not be excluded for any drug used for the treatment of cancer on the grounds that the drug has not been approved by the federal Food and Drug Administration provided the use of the drug is a medically accepted indication for the treatment of cancer. A drug use that is covered under the previous sentence may not be denied coverage based on a “medical necessity” requirement except for a reason unrelated to the legal status of the drug use. Coverage is also provided for medically necessary services associated with the administration of the drug.

Benefit payments will be subject to any Deductible, Co-payment, Coinsurance rate, Benefit Maximum, and Benefit Period shown in the Schedule of Benefits.

As used in this section:

“Medically accepted indication” includes any use of a drug that has been approved by the federal Food and Drug Administration and includes another use of the drug if that use is prescribed by the Insured’s treating oncologist and supported by medical or scientific evidence. As used in this section, “medical or scientific evidence” means one or more of the following sources:

(a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(b) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR).

(c) Medical journals recognized by the federal Secretary of Health and Human Services, under Section 1861(t)(2) of the federal Social Security Act.


(e) Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Center for Medicare and Medicaid Services, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.

(f) Peer-reviewed abstracts accepted for presentation at major medical association meetings.

Tobacco Cessation Benefit

Coverage will be provided for a three-month supply per year of tobacco cessation medication, including over-the-counter medication, if prescribed by a licensed health care practitioner for an Insured.

“Tobacco cessation medication” means all therapies approved by the federal Food and Drug Administration for use in tobacco cessation.
Telemedicine Services Benefit

We will provide coverage for telemedicine services delivered to a patient in a health care facility to the same extent that the services would be covered if they were provided through in-person consultation. For purposes of this section, “telemedicine” means the delivery of health care services such as diagnosis, consultation, or treatment through the use of live interactive audio and video over a secure connection that complies with the requirements of the Health Insurance Portability and Accountability Act of 1996. Telemedicine does not include the use of audio-only telephone, e-mail, or facsimile.

Preventive Services

In addition to any other preventive benefits described in the contract, Company shall cover the following preventive services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any covered individual receiving any of the following benefits for services received from participating providers:

(1) Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, with respect to the individual involved;
(2) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved. For purposes of this section, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention;
(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
(4) With respect to women, evidence-informed preventive care and screenings recommended in comprehensive guidelines supported by the Health Resources and Services Administration.

In addition to any other wellness benefits described in the contract, We will provide the following Women’s Preventive Services and shall not impose any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amount to any covered individual receiving any of the following benefits for services received:

(1) Well-woman visits: benefits are payable for one well-woman preventive care visit per Benefit Period for an adult woman to obtain the recommended preventive screening services that are age appropriate and developmentally appropriate, including preconception and one visit for prenatal care. This benefit does not include coverage for routine pregnancy, delivery and well-baby charges.

More than one visit may be needed to obtain all the recommended preventive screening services, depending on a woman’s health status, health needs and other risk factors. Additional well-woman visits will be covered if the doctor determines they are necessary to help establish what preventive screening services are appropriate and to set up a plan to help the woman get the care she will need to be healthy.
For covered preventive screening services, Deductible, Copay and/or Coinsurance cost-sharing requirements may apply to the office visit if (a) the preventive screening service is billed separately from the office visit, or (b) the primary purpose of the office visit is other than the delivery of preventive screening services and the preventive screening service is not billed separately from the office visit.

For covered preventive screening services cost-sharing requirements will not be applied to the office visit if (a) the preventive screening service is not billed separately from the office visit and (b) the primary purpose of the office visit is the delivery of the preventive screening services.

For any recommended preventive screening services or items that do not specify a frequency, method, treatment, or setting for the provision of that service, We may use reasonable medical management to determine any coverage limitations. We may rely on established techniques and the relevant evidence base to determine the frequency, method, treatment, or setting for which a recommended preventive screening service will be covered without cost-sharing requirements to the extent not specified in a recommendation or guideline.

(2) Screening for gestational diabetes: benefits are payable for one screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be high risk for diabetes. This benefit does not include coverage for routine pregnancy, delivery and well-baby charges.

(3) Human papillomavirus testing: high-risk human papillomavirus DNA testing in women with normal cytology results. One screening is covered for females 30 years of age and over and will be covered no more frequently than once every 3 years.

(4) Counseling for sexually transmitted infections: benefits are payable for one counseling session per Benefit Period for counseling on sexually transmitted infections for all sexually active women.

(5) Counseling and screening for human immune-deficiency virus: benefits are payable for one counseling session and screening per Benefit Year for human immune-deficiency virus infection for all sexually active women.

(6) Contraceptive methods and counseling: when prescribed by Your Provider, benefits are payable for all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity. This benefit does not include coverage for abortifacient drugs.

(7) Breastfeeding support, supplies and counseling in conjunction with each birth: benefits are payable for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period. Coverage includes the costs for the rental of breastfeeding equipment. This benefit does not include coverage for routine pregnancy, delivery and well-baby charges.

(8) Screening and counseling for interpersonal and domestic violence: benefits are payable for screening and counseling for interpersonal and domestic violence per Benefit Period.

(9) Sexual Assault Examination: benefits are payable for the sexual assault examination of a victim of alleged sexual assault. No co-payment or coinsurance or, to the extent permitted under federal law, deductible or other cost-sharing requirement will be imposed for the sexual assault examination of a Covered Person who is the victim of alleged sexual assault for health care services associated with a sexual assault examination.
As used in this section:

“Sexual assault examination” means either or both of the following:

(a) A physical examination of the patient, documentation of biological and physical findings, and collection of evidence; and

(b) Treatment of the patient’s injuries; providing care for sexually transmitted infections; assessing pregnancy risk; discussing treatment options including reproductive health services, screening for the human immunodeficiency virus, and prophylactic treatment when appropriate; and providing instructions and referrals for follow-up care.

Essential Health Benefits

Notwithstanding anything herein to the contrary, this policy covers all Essential Health Benefits, in accordance with Section 1302(a)(1) and (b) of the Patient Protection and Affordable Care Act, and all regulations and guidance issued thereunder.

GENERAL POLICY EXCLUSIONS

The Policy does not provide coverage for loss caused by or resulting from:

1. Charges that are not Medically Necessary or in excess of the Usual and Customary charge.

2. Expenses in connection with vision services and prescriptions for adults, including eye examinations, eye refractions, eye glasses or contact lenses, or the fitting of eyeglasses or contact lenses, radial keratotomy or laser surgery for vision correction or the treatment of visual defects or problems except as specifically provided for in the Policy.

3. Expenses in connection with cosmetic treatment or cosmetic surgery, except as a result of:
   a. medically necessary reconstructive surgery with prior approval of physician;
   b. a covered Injury that occurred while the Covered Person was insured;
   c. a covered child's congenital defect or anomaly; or
   d. as specifically provided for in the Policy.

4. Drugs and medications for the treatment of impotence and/or sexual dysfunction.

5. Reproductive/Infertility procedures and fertility tests, including but not limited to: family planning, fertility tests, infertility (male or female), including any supplies rendered for the purpose or with the intention of achieving conception; premarital examinations. Examples of fertilization procedures are: ovulation induction; in vitro fertilization; embryo transplant; or similar procedures that augment or enhance the Covered Person's reproductive ability; impotence organic or otherwise.

6. War, or any act of war, whether declared or undeclared; service in the Armed Forces of any country. Loss which occurs during or as a result of committing or attempting to commit an assault, felony, or participation in a riot or insurrection, engaging in an illegal occupation.

7. Expenses incurred for Injury or Sickness for which benefits are paid or payable under any Worker's Compensation or Occupational Disease Law or Act, or similar legislation.

8. Treatment, services, supplies, in a Veteran's Administration or Hospital owned or operated by a national government or its agencies unless there is a legal obligation for the Covered Person to pay for the treatment.

9. Except as specifically provided for in the Policy, expenses incurred for dental care or treatment of the teeth, gums or structures directly supporting the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries to sound natural teeth caused by a covered Injury, and as specifically provided in the Hospitalization and Anesthesia for Dental Procedures expense benefit.
10. Expenses incurred for acupuncture.
11. Except as otherwise provided under the Early Childhood Developmental Disorders Benefit, Autistic disease of childhood, hyperkinetic syndromes, milieu therapy.
12. Except as otherwise provided in this Policy, Elective Surgery or Elective Treatment.
13. Foot care including: flat foot conditions, supportive devices for the foot, subluxations, care of corns, bunions (except capsular or bone surgery), calluses, toenails, fallen arches, week feet, foot strain, and symptomatic complaints of the feet, except those related to diabetic care.
14. Hearing aids or other treatment for hearing defects or problems, except as otherwise provided in this Policy. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process.
15. Hirsutism, alopecia.

NON-DUPLICATION OF BENEFITS LIMITATION

If benefits are payable under more than one (1) benefit provision contained in the Policy, benefits will be payable only under the provision providing the greater benefit.

COORDINATION OF BENEFITS (COB)

A. APPLICABILITY

Coordination of benefits is a limitation of benefits designed to avoid the duplication of payments for Covered Expenses. Coordination of benefits under this section applies when a Covered Member has healthcare coverage under one (1) or more policies or plans that contain a coordination of benefits provision (or are required by law to contain a coordination of benefits provision).

B. COORDINATION OF BENEFITS WITH AUTO INSURANCE

If the Covered Member resides in a state where automobile no-fault, personal injury protection, or medical payments coverage is mandatory, or if the Covered Member is involved in an accident in a state where such coverage is mandatory and the Covered Member’s automobile insurance carrier provides the state mandated coverage, the Covered Member’s automobile coverage is primary and the Policy takes a secondary status.

C. ORDER OF DETERMINATION RULES

When a Covered Member’s claim is covered under both this Policy and another policy, this Policy is a Secondary Policy and the availability of benefits is determined after benefits are determined under the other policy unless:

1. There is a statutory requirement relating to the determination of benefits which prohibits this Policy from being a Secondary Policy; or,
2. Both the other policy’s rules and this Policy’s rules require that benefits be determined under this Policy before those of the other policy.

D. EFFECT ON BENEFITS OF THIS POLICY

1. This Policy as Primary Policy

When this Policy is the Primary Policy, the Benefits shall be determined without consideration of the benefits of any other Plan.
2. This Policy as Secondary Policy

When this Policy is a Secondary Policy, the Benefits will be reduced when the sum of the following exceeds the Covered Expenses in a benefit year:

a. The Covered Expenses in the absence of this coordination of benefits provision; plus
b. The expenses that would be payable under the other Plan, in the absence of provisions with a purpose like that of this coordination of benefits provision, whether or not a claim is made.

When the sum of these two (2) amounts exceeds the maximum amount payable for Covered Expenses in a Benefit Year, the Covered Expenses will be reduced so that they and the benefits payable under the Primary Plan do not total more than the Covered Expenses. When the Covered Expenses of this Policy are reduced in this manner, each benefit is reduced in proportion and then charged against any applicable limit of this Policy.

**PREMIUMS**

**Premiums:** The premiums for this Policy will be based on the rates currently in force, the plan and amount of insurance in effect.

**Changes In Premium Rates:** We may change the premium rates from time to time with at least 31 days advanced written notice. No change in rates will be made until 12 consecutive months after the Policy Effective Date. An increase in rates will not be made more often than once in a 12-month period.

**Payment of Premium:** The first Premium is due on the Policy Effective Date. After that, premiums will be due monthly unless We agree with the Policyholder on some other method of premium payment. We will provide You with notice of payment due at least 21 days before the due date.

If any premium is not paid when due, the Policy will be canceled as of the Premium Due Date, except as provided in the Policy Grace Period section.

**Policy Grace Period:** A Policy Grace Period of 31 days will be granted for the payment of the required premiums. The Policy will remain in force during the Grace Period. If the required premiums are not paid during the Policy Grace Period, insurance will end on the last Premium Due Date on which required premiums were paid. The Policyholder will be liable to Us for any unpaid premium for the time the Policy was in force. The Insurer will remain liable for any claims for covered losses incurred during the Grace Period.

**Reinstatement:** If any renewal premium is not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Insurer or by any agent duly authorized by the Insurer to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy; provided, however, that if the Insurer or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Insurer or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the Insurer has previously notified the Insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than ten days after such date. In all other respects the Insured and Insurer shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.
Currency: All premiums for and claims payable pursuant to the Policy are payable only in the currency of the United States of America.

GENERAL PROVISIONS

Entire Contract: This policy, including the endorsements, the attached papers, if any, and the signed application of the Policyholder, constitutes the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Insurer and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

Physical Examination and Autopsy: We, at our own expense, have the right and the opportunity to examine the person of the Insured when and as often as it may reasonably require during the pendency of a claim hereunder and to make an autopsy in case of death where it is not forbidden by law.

Right of Reimbursement: If a Covered Person incurs expenses for Sickness or Injury that occurred due to the negligence of a third party: (a) We have the right to reimbursement for all benefits We have paid from any and all damages collected from the third party for those same expenses whether by action at law, settlement or compromise by the Covered person, Covered Person's parents, if the Covered Person is a minor, or Covered Person's legal representative as a result of that Sickness or Injury, and (b) We are assigned the right to recover from the third party, or his or her Insurer, to the extent of the benefits paid for that Sickness or Injury.

We shall have the right to reimbursement out of all funds that the Covered Person, the Covered Person's parents, if the Covered Person is a minor, or the Covered Person's legal representative, is or was able to obtain for the same expenses we have paid as a result of that Sickness or Injury.

The Covered Person or the Covered Person's parents if the Covered Person is a minor is required to furnish any information or assistance or provide any documents that we may reasonably require in order to obtain our rights under this provision. This provision applies whether the third party admits liability or not.

Right of Recovery: If We make payments with respect to benefits payable under the Policy in excess of the amount necessary, We shall have the right to recover such payments. We shall notify the Covered Person of such overpayment and request reimbursement from the Covered Person. However, should the Covered Person not provide such reimbursement, We shall have the right to offset such overpayment against any other benefits payable to the Covered Person under the Policy to the extent of the overpayment.

Legal Actions: No action at law or in equity may be brought to recover on the Policy prior to the expiration of 60 days after written proof of loss has been furnished in accordance with the requirements of the Policy. No such action may be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Incontestability: No misstatements, except fraudulent misstatements, made by the applicant in the application for such policy, shall be used to void the policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of two years.
CLAIMS FILING AND APPEAL PROCEDURES

A. CLAIMS FILING PROCEDURES

Notice of Claim
Written notice of claim must be furnished to Companion Life Insurance Company or its administrator at Consolidated Health Plans, 2077 Roosevelt Ave., Springfield, MA 01104, within twenty (20) days after the event on which the claim is based, or as soon thereafter as is reasonably possible. Notice of claim given by or on behalf of the Covered Person to the Insurer at the above address should include sufficient information to identify the Insured, including the Policyholder’s name, Covered Person’s name, and Policyholder’s Policy Number. Failure to give notice within the time does not invalidate nor reduce any claim if the claimant can show that it was not reasonably possible to give the notice within the required time frame and if notice was given as soon as reasonably possible.

Claim Forms
Upon receipt of Notice of Claim, the Company will furnish or cause to be furnished to the claimant such forms as are usually furnished by the Company for filing proofs of claims. If the claim form is not furnished within fifteen (15) days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this policy as to proof of loss upon submitting, with the time fixed in the policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which the claim is made.

Time of Payment of Claims
We will pay all benefits as soon as possible, but no later than 30 days after receipt of due proof. (“Due proof” means all information necessary for Us to adjudicate the claim properly.) A valid claim not paid within this time period will be increased by interest at 12% per year until the claim is settled. If we do not pay when due, the Insured may bring action to recover such benefits and any other damages.

Payment of Benefits
All benefits will be paid to the Insured or the Insured’s designee unless benefits have been assigned to the facility or provider directly. If an Insured dies while benefits, if any, are unpaid, we may, at our option, pay the benefits to the designated beneficiary or to the estate of the Insured. Any equitable payment made in good faith will release Us from liability to the extent of payment.

Proof of Claim
1. The Company must receive the claim within ninety (90) days after the beginning of services. Failure to file the claim within the ninety (90) days period, however, will not prevent payment of Covered Expenses if the Insured shows that it was not reasonably possible to file the claim timely, provided the claim is filed as soon as is reasonably possible. In any event, except in the absence of legal capacity, claims must be filed must be filed no later than one year from the time the claim is otherwise required.

Receipt of a claim by the Company will be deemed written proof of loss and will serve as written authorization from the Insured to the Company to obtain any medical or financial records and documents useful to the Company. The Company, however, is not required to obtain any additional records or documents to support payment of a claim and is responsible to pay claims only on the basis of the information supplied at the time the claim was processed. Any party who submits medical or financial reports and documents to the Company in support of an Insured’s claim will be deemed to be acting as the agent of the Insured.
Payment of Claim

1. There are three (3) types of claims: Post-Service Claims, Urgent Care Claims and Concurrent Care Claims. The Company will make a determination for each type of claim within the time periods set forth below.

Post-Service Claim. A Post-Service Claim is any claim for benefits that is not a Pre-Service Claim. A determination on a Post-Service Claim will be sent within a reasonable time period, but no later than thirty (30) days from receipt of the claim.

An extension of fifteen (15) days may be necessary if the Company determines that, for reasons beyond the control of the Company, an extension is necessary. If an extension is necessary, the Company will notify the claimant within the initial thirty (30) day time period that an extension is necessary, the circumstances requiring the extension, and the date the Company expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information. The claimant will have at least forty-five (45) days to provide the required information. If the Company does not receive the required information within the forty-five (45) day time period, the claim will be denied. The Company will make its determination within fifteen (15) days of receipt of the requested information, or, if earlier, the deadline to submit the information.

Urgent Care Claim. An Urgent Care Claim is any Pre-Service or Post-Service Claim for medical care or treatment with respect to which the application of the standard time periods for making non-Urgent Care Claims determinations (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Any claim that a physician with knowledge of the claimant’s medical condition determines is an Urgent Care Claim will be treated as such.

An Urgent Care Claim determination will be sent to the claimant in writing or in electronic form as soon as possible, taking into account the medical exigencies, but no later than seventy-two (72) hours from receipt of the claim. If the claim is determined to be incomplete, the claimant will be sent a notice to this effect within twenty-four (24) hours of receipt of the claim. The claimant will then have forty-eight (48) hours to provide the additional information. Failure to provide the additional information within forty-eight (48) hours may result in the denial of the claim.

If the claimant requests an extension of urgent care benefits beyond an initially determined period and makes the request at least twenty-four (24) hours prior to the expiration of the original determination period, the claimant will be notified within twenty-four (24) hours of receipt of the request for an extension.

Concurrent Care Claim. A Concurrent Care Claim is any claim for benefits for which an ongoing course of treatment has been approved, to be provided over a period of time or number of treatments. The claimant will be notified if there is to be any reduction or termination in coverage for ongoing care, sufficiently in advance of such reduction or termination to allow the claimant time to appeal the decision before the Benefits are reduced or terminated.
2. Notice of Determination

a. If the claimant’s claim is filed properly, and the claim is in part or wholly denied, the claimant will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:

i. Include information sufficient to identify the claim involved (including date of service, health care provider, claim amount (if applicable) and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings);

ii. State the specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim.

iii. Reference the specific policy provision(s) on which the determination is based;

iv. State that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

v. Describe additional material or information, if any, needed to complete the claim and the reasons such material or information is necessary;

vi. Describe the claims review procedures under this policy and the time limits applicable to such procedures, including information regarding how to initiate such appeals;

vii. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information is available free of charge upon request);

viii. If the reason for denial is based on a lack of Medical Necessity or Investigational or Experimental Services exclusion or similar limitation, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request); and

ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes.

b. The Insured will also receive a notice if the claim is approved.

c. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support a denial of benefits.

d. All claims will be decided pursuant to a good faith interpretation of the policy, in the best interest of Insured or Dependent, without taking into account either the amount of the benefits that will be paid or the financial impact on the Company.
B. Appeal Procedures for an Adverse Benefit Determination

The following appeal procedures apply in connection with an Adverse Benefit Determination only. These procedures do not apply to an exception review request for a Prescription Drug that is not otherwise covered under this policy, as described under the Prescription Drug Benefit section.

1. Claimant has one hundred eighty (180) days from receipt of an Adverse Benefit Determination to file an appeal. An appeal must meet the following requirements:
   a. An appeal must be in writing; and,
   b. An appeal must be sent (via U.S. mail) to Company or its administrator at the address on the Insured’s Identification Card; and,
   c. The appeal request must state that a formal appeal is being requested and include all pertinent information regarding the claim in question; and,
   d. An appeal must include the Insured’s name, address, social security number and any other information, documentation or materials that support the Insured’s appeal.

2. The Insured will have the opportunity to submit written comments, documents, or other information in support of the appeal and will have access, upon request, to all documents relevant to the claim. A person other than the person who made the initial decision will conduct the appeal. No deference will be afforded to the initial determination.

3. If the appealed claim involved an exercise of medical judgment, the Company will consult with an appropriately qualified health care practitioner with training and experience in the relevant field of medicine. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on the appeal.

4. The Company will decide the appeal within the time periods specified below:
   - Urgent Care Claim: The claimant may request an expedited appeal of an Urgent Care Claim. This expedited appeal request may be made orally, and the Company will communicate with the claimant by telephone or facsimile. The Company will decide the appeal within a reasonable period of time, taking into account the medical circumstances, but no later than seventy-two (72) hours after receipt of the request for an expedited appeal.
   - Post-Service Claim: The Company will decide the appeal within a reasonable period of time, but no later than sixty (60) days after receipt of the appeal.
   - Concurrent Care Claim: The Company will decide the appeal of Concurrent Care Claims within the time frames set forth above, depending on whether such claim is also a Pre-Service Claim, an Urgent Care Claim or a Post-Service Claim.

5. Notice of Appeals Determination.
   a. If a claimant’s appeal is denied in whole or in part, the claimant will receive notice of an Adverse Benefit Determination, in a culturally and linguistically appropriate manner, that will:
i. Include information sufficient to identify the claim involved (including date of service, health care provider, claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings;

ii. State specific reason(s) for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the standard (if any) that was used in denying the claim and a discussion of the decision;

iii. Reference specific provision(s) of the policy on which the benefit determination is based;

iv. State that the Insured is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim for Benefits.

v. Describe any voluntary appeal procedures offered by the Company and the claimant’s right to obtain such information;

vi. Disclose any internal rule, guideline, or protocol relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request);

vii. If the reason for an Adverse Benefit Determination on appeal is based on a lack of Medical Necessity, Investigational or Experimental Services or other limitation or exclusion, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

viii. Provide a description of available external review processes, including information regarding how to initiate an external review; and

ix. Disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under section 2793 of the Public Health Service Act, to assist individuals with the internal claims and appeals and external review processes.

b. The claimant will also receive, free of charge, any new or additional evidence considered, relied upon, or generated in connection with the claim. This evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on appeal is received, to give the claimant a reasonable opportunity to respond prior to that date.

c. If the Adverse Benefit Determination on appeal is based on a new or additional rationale, then the claimant will be provided with the rationale, free of charge. The rationale will be provided as soon as possible and sufficiently in advance of the date of the Adverse Benefit Determination to give the claimant a reasonable opportunity to respond prior to that date.
d. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual will be made based upon the likelihood that the individual will support a denial of benefits, or upholding of an Adverse Benefit Determination.

e. All appeals will be decided pursuant to a good faith interpretation of the policy, in the best interest of Insured or Dependent, without taking into account either the amount of the benefits that will be paid or the financial impact on the Company.

f. The claimant will also receive a notice if the claim on appeal is approved.

g. The claimant must raise all issues and grounds for appealing an Adverse Benefit Determination at every stage of the appeals process, or such issues and grounds will be deemed permanently waived.

C. EXTERNAL REVIEW PROCEDURES

The following external review procedures apply in connection with an Adverse Benefit Determination for which the appeal procedures described in paragraph B have been exhausted. These procedures do not apply to an external exception review request for a Prescription Drug that is not otherwise covered under this policy, as described under the Prescription Drug Benefit section.

An Insured who has exhausted all applicable internal review procedures provided by the health benefit plan shall have the right to an independent external review of a decision under a health benefit plan to deny, reduce or terminate health care coverage or to deny payment for a health care service. The independent review shall be available when requested in writing by the affected Insured, provided the decision to be reviewed is based on one of the following reasons:

(1) The health care service is a covered benefit that the health Insurer has determined to be not medically necessary.
(2) A limitation is placed on the selection of a health care provider that is claimed by the Insured to be inconsistent with limits imposed by the health benefit plan and any applicable laws and rules.
(3) The health care treatment has been determined to be experimental, investigational or an off-label drug. A health benefit plan that denies use of a prescription drug for the treatment of cancer as not medically necessary or as an experimental or investigational use shall treat any internal appeal of such denial as an emergency or urgent appeal, and shall decide such appeal within the time frames applicable to emergency and urgent internal appeals under rules adopted by the Commissioner.
(4) The health care service involves a medically based decision that a condition is preexisting.

The written request must be made within 120 days or 4 months whichever is longer from any of the following to occur:

(1) Receipt of written documentation of the health benefit plan’s final grievance decision and notice of appeal rights,
(2) The insurer having waived the required grievance process, or
(3) The insurer is deemed to have waived the grievance process by failing to adhere to grievance process time requirements.
The right to review under this section shall not be construed to change the terms of coverage under a health benefit plan. The Insured has the rights to be provided with adequate notice of their review rights under this section, to use outside assistance during the review process and to submit evidence relating to the health care service, and to be protected from retaliation for exercising their right to an independent external review under this section. The application fee may be waived or reduced based on a determination by the Commissioner of the Vermont Department of Financial Regulation that the financial circumstances of the Insured warrant a waiver or reduction. The application fee shall be paid by the Insurer, not the Insured, if the independent review organization reverses an Insurer's decision to deny payment for a health care service. Other costs of the independent review shall be paid by the health benefit plan.

The independent external reviews shall be conducted by independent review organizations pursuant to a contract with the Department of Financial Regulation, and the reviewers shall include health care providers credentialed with respect to the health care service under review and have no conflict of interest relating to the performance of their duties under this section. The independent external reviews shall be conducted in accordance with standards of decision-making based on objective clinical evidence and shall resolve all issues in a timely manner and provide expedited resolution when the decision relates to emergency or urgent health care services. The independent review organization shall issue to both parties a written review decision that is evidence-based. The decision shall be binding on the health benefit plan. The confidentiality of any health care information acquired or provided to the independent review organization shall be maintained in compliance with any applicable State or federal laws. The records of, and internal materials prepared for specific reviews by any independent review organization under this section shall be exempt from public disclosure.

Within five (5) business days of receiving the request, the Department shall:

1. Accept the request for an independent external review if it determines that:
   a. The individual is or was an Insured of the health insurer;
   b. The service that is the subject of the independent external review reasonably appears to be a covered service under the benefits provided by contract to the insured;
   c. The independent external review involves an appealable decision;
   d. The Insured has exhausted the health insurer’s required internal grievance process as required by law; and
   e. The Insured has provided all information required by the Department.

2. Select an independent review organization on a rotating basis and determine whether it is able to accept the assignment. If the organization has a conflict of interest, does not have a reviewer available who is knowledgeable about the procedure or treatment, or is otherwise not able to accept the assignment, the Department shall assign the independent external review to the next independent review organization on the list without a conflict that is able to accept the assignment.

3. Notify the Insured and the insurer of the specialty of the reviewer who has been assigned by the independent review organization.

Upon completion of its review, the Department shall notify the Insured and the health insurer and, if applicable, the mental health review agent whether the application for independent external review has been accepted. If the application for independent external review is accepted, the Department shall also notify the parties of their opportunity to submit information and supporting documentation for consideration by the applicable independent review organization. Such information and documentation shall include:
(1) **Documentation to be submitted by the health insurer and, if applicable, the mental health review agent:** All relevant documents, records or other information in its possession or control, including the review criteria used in making the decision being appealed, copies of any applicable policies or procedures, and copies of all medical records considered by the insurer in making its initial decision and its decisions pursuant to the internal grievance process. The health insurer, and, if applicable, the mental health review agent, shall consecutively number the pages in its documentation and identify the total number of pages.

(2) **Documentation to be submitted by the Insured:** All medical records and any additional information that the Insured would like to have considered by the independent review organization, which may include at the Insured’s discretion written statements by either the Insured and/or his or her health care providers, or both, relating to the subject of the independent external review.

The information and supporting documentation required in the above paragraph must be submitted to the Department within ten (10) days from the date the notice was received, except as follows:

(1) Health insurers and mental health review agents, if applicable may request an extension of up to ten (10) days in which to submit the information and documentation, which shall be granted by the Department only for good cause shown.

(2) Insureds may request an extension within which to submit their information and supporting documentation for any reason, except that the Department may set a final deadline for submission if the Insured has not submitted his or her information after having been granted multiple extensions.

The Department shall provide copies of the information and supporting documentation filed by the Insured and the health insurer to the other and to the independent review organization. Each shall have three (3) business days from receipt of the copies to file responsive information or documentation with the Department.

Within 10 business days of the date of receipt by the independent review organization of the external appeal, the Insured or the health insurer may submit additional information or supporting materials to the Department. The additional information or supporting materials shall be sent by the Department to the other party, who shall have three (3) business days after receipt within which to file any additional responsive information or supporting materials. All such information shall then be sent by the Department to the independent review organization for review as part of the independent external review.

D. **EXPEDITED REVIEW PROCEDURES**

Upon receipt of a request for independent external review that is the result of a grievance that has been designated as expedited, or that the Department in its sole discretion determines shall be expedited, the Department shall immediately accept the request. Oral request for reviews related to emergency or urgent services may be accepted if the Insured completes and submits an application form and filing fee, if applicable, as soon thereafter as possible.

Upon acceptance of the request for expedited independent external review, the Department will immediately notify the health insurer and the Insured by the most expeditious means available, including telephone, fax or e-mail of their right to submit information and supporting documentation. Such information must be submitted to the Department in a time frame consistent with the medical exigencies of the case but in no event later than 24 hours after the acceptance of the request.
Immediately upon receipt of the supporting information and documentation from the Insured and the insurer, but in no event more than 24 hours after accepting the request for expedited review, the Department shall assign the independent external review to an independent review organization for clinical review. The independent review organization shall complete its review and make a determination as soon as possible consistent with the medical exigencies of the case, but in no event more than three (3) days after receipt of the request for an independent external review, unless upon further review it determines that the appeal does not involve emergency or urgently needed services, in which case the deadline for review shall not exceed 30 days.

If the expedited independent external review relates to services currently being provided to an Insured in a health care facility or other previously approved course of treatment, and the request for expedited independent external review is made within 24 hours of the receipt by the Insured of (1) the final grievance decision and (ii) the notice of appeal rights, whichever shall be later received, and the expedited external review is conducted in accordance with the time frames specified by law, the services shall be continued by the insurer without liability to the Insured until:

1. The independent external review decision is issued, and
2. The insurer has authorized coverage for a medically safe and appropriate discharge or transition plan developed after consultation with the member’s treating physician or the treating health care provider’s designee.

When the expedited independent external review relates to services not currently being provided to an Insured in a health care facility or other course of treatment and those services by contract require prior authorization from the insurer before being rendered, and the independent review organization reasonably believes that the delay caused by the review may cause significant harm to the Insured and so notifies the Department, the Department shall order the health insurer to provide coverage for the contested services pending the final determination of the appeal independent external review. If the insurer’s denial is upheld by the independent review organization, the Insured will be responsible for reimbursing the insurer for the costs of such services paid for while the appeal was pending.

Health insurers and mental health review agents shall have qualified and informed personnel available 24 hours a day, seven (7) days per week, who can respond to Department requests and assist the Department and/or independent review organization in assessing and processing potential cases and cases accepted for expedited review. Health insurers and mental health review agents shall provide the Department with updated contact information for such personnel annually and prior to any changes and shall ensure that all of their personnel are trained to facilitate such communication with the Department if requested.

E. CONTACT INFORMATION

For further assistance, you may contact Companion Life Insurance Company at (803) 735-1251 or (800) 753-0404, the Vermont Department of Financial Regulation at (802) 828-3302 or (800) 964-1784, or the Vermont Office of the Health Care Advocate at (802) 863-2316 or (800) 917-7787.

The Vermont Department of Financial Regulation’s Health Insurance Consumer Services unit can provide free help to you if you need general information about health insurance, have concerns about our activities, or are not satisfied with how we resolve your complaints.

The Vermont Office of Health Care Advocate’s telephone hotline service can provide you with free help if you have problems or questions about health care or health insurance.
Companion Life Insurance Company

Companion Life Insurance Company (CL) is committed to protecting the privacy of the personal information we receive ("Information") about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is “your privacy is our priority.”

Why We Collect and How We Use Information:
When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other CL products or services.

Types of Information We Collect:
We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we could collect include, but are not limited to:
- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

We also may keep Information about your transactions with us:
- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:
- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:
Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

CL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other CL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, CL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:
You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

Massachusetts Policyholders: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

How We Protect Your Information:
CL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on CL’s website, www.companionlife.com.
NOTICE OF PRIVACY PRACTICES

COMPANION LIFE INSURANCE COMPANY
Columbia, SC

As Required by the Privacy Regulations Promulgated Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR PRIVACY PROMISE

We understand the importance of handling your medical information with care. We are committed to protecting the privacy of your medical information. State and federal laws require us to make sure that your medical information is kept private. Federal law requires that we provide you with this Notice of Privacy Practices, which describes our legal duties and privacy practices with respect to your medical information and your legal rights with respect to our use and disclosure of your medical information. We are required by law to follow the terms of the Notice currently in effect. This Notice is effective September 23, 2013, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. These changes will be effective for all medical information that we keep, including medical information we created or received before we made the changes. When we make a material change to our privacy practices, we will provide a copy of a new notice (or information about the changes to our privacy practices and how to obtain a new notice) in a mailing to members who are covered under our health plans at that time.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Treatment, Payment, Health Care Operations: We may use and disclose your medical information for purposes of treatment, payment and health care operations.

Payment: We may disclose your medical information to a physician or other health care professional to help him or her provide your treatment.

Payment: We may use or disclose your medical information for these and other activities related to payment:

- Paying claims from physicians, hospitals and other health care providers.
- Obtaining premiums.
- Issuing explanations of benefits to the named insured.
- Providing information to health care professionals or other entities that are bound by the federal Privacy Rules for their payment activities.

Health Care Operations: We may use or disclose your medical information in the normal course of conducting health care operations, including such activities as:

- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals.
- Compliance and detection of fraud and abuse.
- Underwriting, enrollment and other activities related to creating, renewing or replacing a plan of benefits. We may not, however, use or disclose genetic information for underwriting purposes.
- Providing information to another entity bound by the federal Privacy Rules for its health care operations, in limited circumstances.

You and Your Family and Friends: We may use and disclose your medical information to communicate with you for purposes of customer service or to provide you with information you request. We may disclose your medical information to a family member, friend or other person to the extent necessary for him or her to assist with your health care or payment for your health care. Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we may, in the exercise of our professional judgment, determine whether the disclosure would be in your best interest. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, -general condition or death.

Your Employer or Organization Sponsoring Your Group Health Plans: We may disclose summary information and enrollment information to your employer or other plan sponsor. Summary information is a summary of the claims history, claims expenses or types of claims that members of your group health plan have filed. The summary information will not include demographic information about you or others in the group health plan, but your employer or plan sponsor may be able to identify individuals from the summary information provided.

Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose our members' medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
• To organ procurement organizations.
• To avert a serious threat to health or safety.
• In connection with certain research activities.
• To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
• To correctional institutions regarding inmates.
• As authorized by state workers’ compensation laws.

Your Authorization: We may not use or disclose your medical information without your written authorization, except as described in this notice. You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it at any time by notifying us of your revocation in writing. Your revocation will not affect any use or disclosure permitted by the authorization while it was in effect. We need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when a disclosure is required by law. We also must obtain your written authorization to sell your medical information to a third party or, in most circumstances, to send you communications about products and services. We do not need your written authorization, however, to send you communications about health-related products or services, as long as the products or services are associated with your coverage or are offered by us.

Individual Rights: You have certain rights with respect to the medical information we maintain about you. To exercise any of these rights or to obtain more information about these rights (including any applicable fees), contact us using the information listed at the end of this notice.

Access: You have the right to inspect or receive a paper or electronic copy of your medical information, with some exceptions. To inspect or receive your medical information, you must submit the request in writing. If you request to receive a copy of your records, we are allowed to charge a reasonable, cost-based fee.

Disclosure Accounting: You have the right to request, in writing, a record of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment, health care operations, and as allowed by law. We will provide you with a record of such disclosures for up to the previous six years. If you request a record of disclosures more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request.

Restriction: You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. By law, we are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions will be made in writing and signed by a person authorized to make such an agreement for us.

Confidential Communications: You have the right to request in writing that we communicate with you about your medical information by other means, or to another location. We are not required to agree to your request unless you state that you could be in danger if we do not communicate to you in confidence. In that case, we must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. We will not be bound to your request unless our agreement is in writing.

Even if we agree to communicate with you in confidence, an explanation of benefits we issue to the named insured for health care services the named insured (or others covered by the health plan) received might contain sufficient information (such as deductible and out-of-pocket amounts) to reveal that you obtained health care services for which we paid.

Amendment: You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

Notice of Breach: We are required to notify affected individuals following a breach of unsecured medical information.

Electronic Notice: You may request a written copy of this notice at any time or download it from our website.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you believe we may have violated your privacy rights, you may submit a complaint to us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information
Attn: Bruce Honeycutt, Privacy Officer
I 20 East @ Alpine Road (AX-E01)
Columbia, SC 29219
(803) 264-7258 (telephone)
(803) 264-7257 (fax)

CLNPP-(4) Rev. 11/13
SECTION I: Application Information

Official School Name: New England Culinary Institute
Attn/Address: ____________________________
School Address: ____________________________
City: Montpelier State: VT Zip: 05602
School Phone: ____________________________ E-Mail Address: ____________________________
Contact Person (if different than above): ____________________________
Title: ____________________________ Dept: ____________________________
Contact’s Phone: ____________________________ Contact’s E-Mail Address: ____________________________
Select ONE Method for Receipt of Policy Confirmation: X E-Mail _____ Fax _____ Mail
Confirmation will be sent by one method ONLY. If you check multiple options, we will send using the first method selected.

SECTION II: Coverage Period and Premium Rate

Annual
Student: $1,433.00
Spouse: $1,433.00
Each Child: $1,433.00

SECTION III: Please Read and Sign Below

The applicant declares the information contained in the application is true and that no material facts have been suppressed or misstated. The applicant understands that incorrect information could void the insurance coverage. The signing of this application does not bind the undersigned to purchase this insurance, nor does the review of the application bind the insurance company to issue a policy. It is agreed that this application shall be the basis of the contract should a policy be issued. Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Signature: ____________________________ Today’s Date (mm/dd/yyyy): _____________
Total Amount of Payment: ____________________________ Desired Effective Date: ____July 1, 2016____

SECTION IV: Agent’s Signature

Agent/Broker (Please Print): ____________________________ License I.D. #: ____________________________
Signature of Agent/Broker: ____________________________ Date: ____________________________