Student Health Insurance

Designed for the Undergraduate and Graduate Students of

UCONN
UNIVERSITY OF CONNECTICUT

Storrs Campus
Regional Campus
2016-2017

Underwritten by:
National Guardian Life Insurance Company
Madison, WI

As Policy form: NBH-280 (2014) CT
Policy Number: 2016I5B19
Group Number: S200595
Effective: 8/15/16 – 8/14/17

Administered by:

CHP Student
Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

WHERE TO FIND HELP

The University of Connecticut Student Health Insurance Plan has been developed especially for The University of Connecticut students for the Regional and Storrs Campus. The Plan provides coverage for Sicknesses and Injuries that occur on and off campus and includes special cost-saving features to keep the coverage as affordable as possible. The University of Connecticut is pleased to offer the Plan as described in this brochure.

For Questions About:	Please Contact:
• **Waiver Process** • **Health Services**	**The University of Connecticut** Student Health Services 234 Glenbrook Road, Unit 2011 Storrs, CT 06269-2011 (860) 486-4456 www.shs.uconn.edu
• **Dependent Enrollment**	**Bailey Agencies, Inc.** 15 Thames Street Groton, CT 06385 Phone: 860-446-8255 or 800-321-4449 Fax: (860) 448-1608 www.baileyagencies.com/college.html
• **Insurance Benefits** • **Preferred Provider Listings** • **Claims Processing** • **Id Card Requests**	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 (800) 633-7867 www.chpstudent.com
• **Preferred Provider Listings**	Consolidated Health Plans **or** http://hcpdirectory.cigna.com/web/public/providers
• **Prescription Drug Providers**	Cigna www.cigna.com

THE UNIVERSITY OF CONNECTICUT STUDENT HEALTH INSURANCE PLAN

The following Certificate of Student Group Health Insurance describes the Injury and Sickness Medical Expense benefits available to The University of Connecticut students. The Plan is underwritten by National Guardian Life Insurance Company. If you are covered by this plan, you will be covered 24 hours a day, on or off campus, throughout the United States and around the world. The exact provisions governing this insurance are contained in the Master Policy. See the University for Additional Information. The Plan is administered by Consolidated Health Plans, 2077 Roosevelt Avenue, Springfield, Massachusetts, 01104.

UCONN STUDENT HEALTH SERVICES (SHS)
STORRS CAMPUS ONLY

234 Glenbrook Road, Storrs, CT 06269-4011
Phone (860) 486-4700
Emergencies call 911
Or
Campus Police (860) 486-4800

HOURS OF OPERATION		
When Classes are in Session	**Monday – Friday**	**8:00 a.m. – 10:30 p.m.**
When Classes are in Session	**Saturday & Sunday**	**8:00 a.m. – 3:30 p.m.**
Summer & School Breaks	**Monday – Friday**	**8:30 a.m. – 4:30 p.m.**
Advice Nurse When Classes are in Session	**Monday - Sunday**	**24 Hours**
Summer & School Breaks	**Saturday & Sunday**	**CLOSED**

The UConn SHS is the University's on-campus health facility. Health Services is staffed by a physician, nurse practitioners and registered nurses.

Any student who has paid the General University Fee is eligible to use Health Services. Students who are registered for credit-bearing courses at Storrs through the College of Continuing Studies are also eligible.

The SHS provides a wide variety of services. This includes primary care visits with doctors, nurse practitioners, nurses and nutritionist. Additional charges may be incurred for laboratory testing, pharmacy items, X-rays, special medical procedures and visits with specialists. The Women's Clinic also charges for annual GYN exams. Many of the charges are reimbursable by this Plan or other private health insurance.

For Students who have purchased the Student Health Insurance coverage, the deductible will be waived when you use the UConn Student Health Services (SHS).

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, **Bailey Agencies, Inc.** 15 Thames Street Groton, CT 06385 Phone: 860-446-8255 or 800-321-4449 Fax: (860) 448-1608 **www.baileyagencies.com/college.html**, or Consolidated Health Plans at 800-633-7867. If You need assistance resolving a complaint, please contact Us at: 1-800-756-3702.

COVERAGE

1. Accident and Sickness coverage begins on August 15, 2016, or the date of enrollment in the plan, whichever is later and ends August 14, 2017.
2. UConn Health Medical & Dental Students Annual only coverage begins August 1, 2016 and ends July 31, 2017.
3. Benefits are payable during the Policy Term, subject to any Extension of Benefits.
4. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.

CERTIFICATE OF
STUDENT GROUP HEALTH INSURANCE
issued by
NATIONAL GUARDIAN LIFE INSURANCE COMPANY, PO BOX 1191, Madison, WI 53701-1191

(Herein referred to as 'We', 'Us' or **'Our')**

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2014) CT. ("the Policy").

Table of Contents

SECTION 1 – Definitions

The terms listed below, if used in this Certificate, have the meanings stated.

Accident means a sudden, unforeseeable external event that causes Injury to an Insured Person. The Accident must occur while an Insured Person's coverage is in effect.

Ambulance Service means transportation to a Hospital by an Ambulance Service.

Amino Acid Modification Preparation means a product intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician.

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

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

Autism Services Provider means any person, entity or group that provides treatment for Autism Spectrum Disorder.

Autism Spectrum Disorder means a pervasive developmental disorder set forth in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Behavioral Therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, Applied Behavior Analysis, cognitive Behavioral Therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an Autism Spectrum Disorder, that are: (A) Provided to children less than fifteen (15) years of age; and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed Physician, or (iii) a licensed psychologist. For the purposes of this subdivision, Behavioral Therapy is supervised by such behavior analyst, licensed Physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the Autism Services Provider by such behavior analyst, licensed Physician or licensed psychologist for each ten hours of Behavioral Therapy provided by the supervised provider.

Brand Name Drugs means drugs for which the drug manufacturer's trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

Cancer Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings, except that a clinical trial for the prevention of cancer is eligible for coverage only if it involves a therapeutic intervention and is a phase Ill clinical trial approved by one of the four entities identified in the Clinical Trial Benefit.

Coinsurance means the ratio by which We and the Insured Person share in the payment of Usual and Reasonable expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these. Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.) Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Copayment means the amount of Usual and Reasonable expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is: 1. Temporarily residing; and 2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

Covered Injury means a bodily injury that is: 1. Sustained by an Insured Person while he/she is insured under the policy or the School's prior policies; and 2. Caused by an accident directly and independently of all other causes.

Coverage under the School's policies must have remained continuously in force: 1. From the date of Injury; and 2. Until the date services or supplies are received; for them to be considered as a Covered Medical Expense under the policy.

Covered Medical Expense means those charges for any treatment, service or supplies that are: 1. Not in excess of the Usual and Reasonable charges therefore; 2. Not in excess of the charges that would have been made in the absence of this insurance; and 3. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which: 1. causes a loss while the Policy is in force; and 2. which results in Covered Medical Expenses.

Deductible means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Policy.

The amount of the Deductible and the frequency (annual or per occurrence) will be shown in the Schedule of Benefits.

Dependent means: 1. Your lawful spouse or lawful Domestic Partner; 2. Your biological or adopted child or stepchild under age 26; and 3. Your unmarried biological or adopted child or stepchild who has reached age 26 and who is: (a) primarily dependent upon You for support and maintenance; and (b) incapable of self-sustaining employment by reason of mental illness or disorder or physical handicap. Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when You enroll a new disabled child under the plan.

Elective Surgery or Elective Treatment means surgery or medical treatment that is: 1. not necessitated by a pathological or traumatic change in the function or structure of any part of the body; and 2. which occurs after the Insured Person's effective date of coverage.

Elective treatment includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include cosmetic surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Eligible Student means a student who meets all enrollment requirements of the School named as the Policyholder in the Insurance Information Schedule.

Emergency Medical Condition means a medical condition which: 1. manifests itself by acute symptoms of sufficient severity (including severe pain); and 2. causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention might result in: (a) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (b) Serious impairment to bodily functions; or (c) Serious dysfunction of any bodily organ or part.

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

Essential Health Benefits mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

Generic Drugs means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

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

Home Health Agency means an agency or organization which meets each of the following requirements: 1. It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services; 2. Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one registered nurse, to govern the services provided; 3. It provides for full-time supervision of such services by a Physician or by a registered nurse; 4. It maintains a complete medical record on each patient; and 5. It has an administrator.

Home Health Care means services provided by a Home Health Agency in the Insured Person's home and shall consist of, but shall not be limited to, the following: 1. Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; 2. Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; 3. Physical, occupational or speech therapy; 4. medical supplies, drugs and medicines prescribed by a Physician, an advanced practice registered nurse or a Physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; and 5. Medical Social Services provided to or for the benefit of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live.

Hospice Care means a coordinated program of home and inpatient care provided directly or under the direction of a properly licensed Hospice. Such services will include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medical directed interdisciplinary team.

Hospital means an institution that: 1. Operates as a Hospital pursuant to law; 2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients; 3. Provides 24-hour nursing service by Registered Nurses on duty or call; 4. Has a staff of one or more Physicians available at all times; and 5) Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

Hospital does not include the following: 1. Convalescent homes or convalescent, rest or nursing facilities; 2. Facilities primarily affording custodial, educational, or rehabilitory care; or 3. Facilities for the aged, drug addicts or alcoholics.

Hospital Confined or Hospital Confinement means a stay of eighteen (18) or more consecutive hours as a resident bed patient in a Hospital.

Immediate Family Member means the Insured Person and his or her spouse or the parent, child, brother or sister of the Insured Person or his or her spouse.

I**nfertility** means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.

Inherited Metabolic Disease means a disease for which newborn screening is required under section 19a-55 (Connecticut), as amended and for cystic fibrosis.

Insured Person means You or Your dependent while insured under the policy.

International Student means an international student: 1. With a current passport and a student Visa; 2. Who is temporarily residing outside of his or her Home Country; and 3. Is actively engaged, on a full time basis, as a student or in educational research activities through the Policyholder. In so far as the policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

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

Low Protein Modified Food Product means a food product that is:

1. Specially formulated to have less than 1 gram of protein per serving; and 2. Intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low protein modified food product does NOT include a natural food that is naturally low in protein.

Medical Social Services mean services rendered, under the direction of a Physician, by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to: 1. Assessment of social, psychological and family problems related to or arising out of such Insured Person's Covered Sickness or Covered Injury and treatment: 1. Appropriate action and utilization of community resources to assist in resolving such problems; and 2. Participation in the development of the overall plan of treatment of such Insured Person.

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

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

Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Mental Health Conditions means mental disorders as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Mental Disorders include alcohol dependency and substance abuse, but do not include mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Occupational Therapy means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a Physician who has certified that the prescribed care and treatment are not available from sources other than the licensed occupational therapist. Such services must be provided in private practice, in a licensed Health Care Facility, or in a Partial Hospitalization program on an exchange basis. The plan must be reviewed and certified at least every two (2) months by the Physician.

Out-of-pocket Expense Limit means the amount of Usual and Reasonable expenses that an Insured Person is responsible for paying.

Pain means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves.

Pain Management Specialist means a Physician who is credentialed by the American Academy of Pain Management or who is a board certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

Palliative Care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he or she experiences the stress of the dying process, rather than at treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Partial Hospitalization means a formal program of care provided in a hospital or facility for periods of less than 24 hours a day.

Participation in a Riot means promotion, conspiring to promote or incite, aiding, abetting or all forms of taking part in a riot but shall not include action taken in an Insured Person's defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order, including, but not limited to police officers and firefighters. Riot shall mean all forms of violence, disorder, or disturbance of the public place by 3 or more persons assembled together, whether or not acting with common intent or whether or not damage to persons or property or unlawful act of acts is the intent or the consequence of such disorder, violence or disturbance.

Physician means a: 1. Doctor of Medicine (M.D.); or 2. Doctor of Osteopathy (D.O.); or 3. Doctor of Dentistry (D.M.D. or D.D.S.); or 4. Doctor of Chiropractic (D.C.); or 5) Doctor of Optometry (O.D.); or 6) Doctor of Podiatry (D.P.M.); who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered. A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, an advanced practice registered nurse, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician. The term Physician does not mean any person who is an Immediate Family Member.

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

Rehabilitative Agency means an agency that provides an integrated multi-treatment program designed to upgrade the function of handicapped, disabled individuals by bringing together, as a team, specialized personnel from various allied health fields.

R**outine Patient Care Costs** with regard to Clinical Trials means: 1. Coverage for Medically Necessary health care services that are incurred as a result of the treatment being provided to the Insured Person for the purposes of the Cancer Clinical Trial that would otherwise be covered if such services were not rendered pursuant to a Cancer Clinical Trial. Such services will include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Insured Person during the course of treatment in the Cancer Clinical Trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the Insured Person were not enrolled in a Cancer Clinical Trial; and 2. Coverage for Routine Patient Care Costs incurred for drugs provided to the Insured Person provided such drugs have been approved for sale by the federal Food and Drug Administration. Routine Patient Care Costs will NOT include: 1. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration; 2. The cost of a non-health care service than an Insured Person may be required to receive as a result of the treatment being provided for the purpose of the Cancer Clinical Trial; 3. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Cancer Clinical Trial; 4. Costs of services that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis or that are performed specifically to meet the requirements of the Cancer Clinical Trial; 5. Costs that would not be covered under this Policy for non-investigational treatments including, but not limited to, items excluded from coverage under the Insured Person's coverage; and 6. Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Cancer Clinical Trial, for any Insured Person or any family member or companion.

School or College means the college or university attended by You.

Skilled Nursing/Rehabilitation Facility means a licensed institution devoted to providing medical, nursing, rehabilitation or custodial care for an Insured Person over a prolonged period, such as during the course of a chronic disease or the rehabilitation phase after an acute sickness or injury.

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

Specialized Formula means a nutritional formula for children up to age twelve (12) that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

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

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

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

Total Disability or Totally Disabled, as it applies to the Extension of Benefits provision, means: 1. With respect to an Insured Person, who otherwise would be employed: (a) His or her complete inability to perform all the substantial and material duties of his or her regular occupation; with (b) care and treatment by a Physician for the Covered Injury or Covered Sickness caused the inability; 2. With respect to an Insured Person who is not otherwise employed: (a) His or her inability to engage in the normal activities of a person of like age and sex; with (b) Care and treatment by a Physician for the Covered Injury or Covered Sickness causing the inability; or (c) His or her Hospital confinement or home confinement at the direction of his or her Physician due to a Covered Injury or a Covered Sickness, except for visits to receive medical treatment.

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

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

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

We, Us, or **Our** means National Guardian Life Insurance Company or its authorized agent.

You, Your means a student of the Policyholder who is eligible and insured for coverage under the policy.

SECTION 2 – ELIGIBILITY, ENROLLMENT, and TERMINATION

The University of Connecticut is making available a Student Health Insurance program underwritten by National Guardian Life Insurance Company and administered by Consolidated Health Plans. Keep this Certificate as no individual policy will be issued. The Master Policy will be available for review upon request. The Master Policy contains the contract provisions.

All full-time undergraduate (12 or more credits) and graduate (9 or more credits) students are required to be covered under the UConn Student Health Insurance Plan, unless they have demonstrated through completion of an Online Waiver, that they are covered under a health insurance policy that provides equal or better benefits than the insurance program offered by the University of Connecticut. Part-time students taking a minimum of six (6) credits of class room attended course work are eligible to voluntarily enroll in the plan. Part-time students should contact Bailey Agencies, Inc. to complete the enrollment.

HOW DO I WAIVE?

Most full-time students will be automatically enrolled in the Student Health Insurance Plan, unless a waiver has been completed by the specified deadline dates listed. The premium for the Plan will be added to your tuition bill. Eligible students who enroll may also insure their eligible dependent(s). To enroll dependent(s), please contact the Bailey Agencies Inc., 15 Thames Street, Suite 100, Groton, CT 06340, 860-446-8255 or toll free at 1-800-321-4449.

Exempt Programs: While most full-time students are automatically billed for the UConn Student Health Insurance Plan, there are some university programs that are exempt from the health insurance requirement. Due to multiple changes of program classification it is advised that ALL students check their tuition fee bill to determine if the fee for the insurance has been posted. If the change has not been posted, you may still be eligible to voluntarily enroll in the student health insurance plan.

If after review of the coverage a student wants to formally decline (waive) the CHP/UConn Student Health Insurance Plan, on online waiver must be completed. The online Waiver is accessed through the student administration (PeopleSoft) system at www.studentadmin.uconn.edu. Your UConn NetID number and unique password are needed to access the system. The only acceptable form of notification to decline the coverage is via the online waiver.

The deadlines to waive coverage are:

- **Fall/Annual Plan - September 15, 2016**
- **Spring Term (new students only) - February 05, 2017**

If you submit an online waiver for the Fall Semester, coverage is automatically waived for the Spring semester; you don't need to submit the waiver again. Only new or transfer students need to complete the online waiver request for the Spring semester.

Waiver submissions may be audited by the University of Connecticut, the Bailey Agencies, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements.

COVERAGE FOR DEPENDENTS

Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person's spouse/domestic partner/including a party to a civil union residing with the insured and dependent biological, adopted or stepchild under age twenty-six (26). Dependent Eligibility expires concurrently with that of the Insured Student.

To enroll the dependent(s) of an eligible student, please contact Bailey Agencies, Inc. directly at (860) 446-8255 or toll free at (800) 321-4449 or go to online at: http://www.baileyagencies.com/college.html. Payment of the premium for dependents is due in full and the acceptable forms of payment are cash, check, money order and/or credit card.

The fall enrollment deadline is **September 15, 2016** and **February 5, 2017** for the spring enrollment. The dependent enrollment application will not be accepted after the fall or spring enrollment deadlines, unless there is a significant life change that directly affects their insurance coverage, such as loss of health coverage under another health plan.

Students may also enroll their Dependent newborn child within sixty-one (61) days (spouse within thirty-one (31)) of an eligible qualifying event. Eligible qualifying events for a Dependent are defined in the Master Policy. Enrollment requests (including payments) received after the required number of days following the qualifying event will not be accepted. Coverage will be effective as of the date of the qualifying event.

EFFECTIVE DATES AND COSTS

1. **Students**: Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on August 15, 2016, and will terminate at 12:01 a.m. on August 15, 2017.
2. **UConn Health Center Medical & Dental Students**: Coverage for all UHC Medical and Dental students will become effective at 12:01 a.m. on August 1, 2016, and will terminate at 12:01 a.m. on July 31, 2017
3. **New Spring Semester Students**: Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 a. m. on January 1, 2017, and will terminate at 12:01 a.m. August 15, 2017.
4. **Insured Dependents**: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premiums are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions as described in the Master Policy. Examples include, but are not limited to, the date the Insured student's coverage terminates and the date the dependent no longer meets the definition of a dependent.

	Annual 8/15/16 – 8/15/17	**Spring 1/1/17 – 8/15/17**
Student*	$3,340	$2,114
Dependent rates are in addition to the student rate		
1 Dependent	$3,290	$2,064
2 Dependents	$6,580	$4,128
3 or more Dependents	$9,870	$6,192

**All costs above include a fee retained by the Servicing Agent.*

TERMINATION DATES

An Insured Person's insurance will terminate on the earliest of: 1. The date this Policy terminates for all insured persons; or 2. The end of the period of coverage for which premium has been paid; or 3. The date an Insured Person ceases to be eligible for the insurance; or 4. The date an Insured Person enters military service; or 5. For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks); 6. For International Students, the date the student ceases to meet Visa requirements; 7. On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error.

Extension of Benefits: Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended as follows: 1. If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the

date his or her insurance terminates, we will continue to pay benefits for up to 31 days from the Termination Date while such confinement continues. 2. If an Insured Person is Totally Disabled due to Covered Injury or Covered Sickness, the coverage for that condition will be extended for up to three months from the Termination Date.

SECTION 3 – STUDENT HEALTH SERVICES REFERRAL

Where available, We recommend but do not require the student use the resources of the Student Health Services (SHS) for non-emergencies where treatment will be administered. Dependent spouses and children are not eligible to use the SHC.

SECTION 4 – BENEFITS

Benefits are payable under the policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Insured Person. **The Covered Medical Expenses for an issued Policy will be only those listed in the Schedule of Benefits.** No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits. Subject to payment of any required Deductible, when you suffer a Loss from Covered Accident or Covered Sickness, we will pay benefits as follows:

Preventive Services: The following services shall be covered without regard to any Deductible, Copayment, or Coinsurance requirement that would otherwise apply: 1. Evidence-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; 2. Immunizations 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 Insured Person involved; 3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Essential Health Benefits: Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, treatment or services are added to the list of Essential Health Benefits by a governing authority, the policy benefits will be amended to comply with such changes.

Treatment of Covered Injury or Covered Sickness

We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to a Covered Injury or Covered Sickness. Benefits payable are subject to:

1. Any specified benefit maximum amounts;
2. Any Deductible amounts;
3. Any Coinsurance amount;
4. Any Copayments;
5. The Maximum Out-of-Pocket Expense Limit; and
6. The Exclusions and limitations provision.

Benefit Period: The first treatment of a Covered Injury or Covered Sickness must begin within the time stated in the Benefit Period shown in the Schedule of Benefits. A Benefit Period begins when the Insured Person experiences a Loss due to Covered Injury or Covered Sickness. The Benefit Period terminates at the end of the period defined in the Schedule of Benefits. Any extension of a Benefit Period, if provided elsewhere in this Policy, is limited to medical treatment of the Covered Injury or Covered Sickness that is ongoing on the termination date of the Insured Person's coverage. The Insured Person's termination date of coverage as it would apply to any other Covered Injury or Covered Sickness will not be affected by such extension.

Out-of-Pocket Expense Limit: The Out-of-Pocket Expense Limit is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Copayments and amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person's Coinsurance amounts will apply toward the Out-of-Pocket Expense Limit.

See NPPO(2014) CT at the end of this certificate.

Inpatient Benefits

Hospital Room and Board Expense, including general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed.

Intensive Care Unit, including 24-hour nursing care. **This benefit is NOT payable in addition to room and board charges incurred on the same date.**

Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as: 1. The cost for use of an operating room; 2. Prescribed medicines; 3. Laboratory tests; 4. Therapeutic services; 5. X-ray examinations; 6. Casts and temporary surgical appliances; 7. Oxygen, oxygen tent; 8. Blood and blood plasma; and 9. Miscellaneous supplies.

Preadmission Testing - We will pay the charges for routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital. These tests must be performed within three working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

Physician's Visits while Confined – We will pay the expenses incurred for Physician's visits not to exceed one visit per day. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services – We will pay benefits for inpatient surgery (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician's visits.

If the surgical procedure is for a Medically Necessary human to human organ transplant, We will also pay benefits for Medically Necessary donor expenses and tests. We will also pay for transportation, lodging, and meal expenses for the Insured Person and one Immediate Family Member for up to $10,000 per episode (time from initial evaluation until the sooner of discharge or cleared to return home).

Registered Nurse's Services, when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.

Physical Therapy while Confined - We will pay the expenses incurred for physical therapy when prescribed by the attending Physician.

Skilled Nursing/Rehabilitation Facility Expense Benefit - the expenses incurred for the services, supplies and treatments rendered to an Insured Person by an Skilled Nursing/Rehabilitation Facility. The Insured Person must enter an Skilled Nursing/Rehabilitation Facility: 1. Within seven (7) days after his/her discharge from a Hospital confinement; 2. Such confinement must be of at least three (3. consecutive days that began while coverage was in force under this Policy; and 3. Was for the same or related Sickness or Accident. Services, supplies and treatments by an Skilled Nursing/Rehabilitation Facility include: 1. Charges for room, board and general nursing services; 2. Charges for physical, occupational or speech therapy; 3. Charges for drugs, biologicals, supplies, appliances and equipment for use in such facility, which are ordinarily furnished by the Skilled Nursing/Rehabilitation Facility for the care and treatment of a confined person; and 4. Charges for medical services of interns, in training, under a teaching program of a Hospital with which the facility has an agreement for such services.

Outpatient Benefits

Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services - We will pay benefits for outpatient surgery (including fees for pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the outpatient surgery benefit or the inpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value.

Outpatient Surgery Miscellaneous - (excluding non-scheduled surgery) surgery performed in a hospital emergency room, trauma center, physician's office, outpatient surgical center or clinic. Benefits will be paid for services and supplies, including: 1. Operating room; 2. Therapeutic services; 3. Oxygen, oxygen tent; 4. Blood and blood plasma; and 5. Miscellaneous supplies.

Physical Therapy - When prescribed by the attending Physician, limited to one visit per day.

Emergency Services Expenses - Only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

In Office Physician's Visits – We will pay the expenses incurred for Physician's office visits. We will not pay for more than one visit per day. Physician's Visit benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

Outpatient Facility Fee - We will pay an outpatient facility fee when an Insured Person is treated for a Covered Sickness or Covered Injury in an appropriately licensed outpatient facility including an ambulatory surgical center. Operating room fees for surgery are paid under the Outpatient Surgery Miscellaneous Benefit and not this benefit.

Diagnostic X-ray Services – We will provide coverage for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a physician.

Laboratory Procedures (Outpatient) – We will provide coverage for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

Shots and Injections - Administered in an emergency room or Physician's office and charged on the emergency room or Physician's statement.

Prescription Drugs - 1. We will pay the expenses incurred for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made; 2. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met: a. The drug is approved by the FDA; b. The drug is prescribed for the treatment of a life-threatening condition; c. The drug has been recognized for treatment of that condition by one of the following: (1. The

American Medical Association Drug Evaluations; (2. The American Hospital Formulary Service Drug Information; (3. The United State Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or (4 Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal. When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items a., b., and c. of this benefit. As it pertains to this benefit, life threatening means either or both of the following: 1. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or 2. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

Outpatient Miscellaneous Expenses (Excluding surgery) - We will pay the charges actually incurred for miscellaneous outpatient expenses (excluding surgery) incurred for the treatment and care of a Covered Injury or Covered Sickness. Expenses must be incurred on the advice of a Physician. Miscellaneous outpatient expenses include other reasonable expenses for services and supplies that have been prescribed by the attending Physician.

Hospice Care Coverage - When, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

Other Benefits

Ambulance Service – We will pay the expenses incurred for transportation to or from a Hospital by ground or air ambulance.

Braces and Appliances - When prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We will also not pay for braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

Durable Medical Equipment - We will pay the expense incurred for the rental or purchase of durable medical equipment, including, but not limited to, Hospital beds, wheel chairs, and walkers. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable medical equipment must: 1. Be primarily and customarily used to serve a medical, rehabilitative purpose; 2. Be able to withstand repeated use; and 3. Generally not be useful to a person in the absence of Injury or Sickness.

Maternity Benefit - We will pay the expenses incurred for maternity charges as follows: 1. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. 2. Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals. **Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child. **Physician-directed Follow-up Care** including: 1. Physician assessment of the mother and newborn; 2. Parent education; 3. Assistance and training in breast or bottle feeding; 4. Assessment of the home support system; 5. Performance of any prescribed clinical tests; and 6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals. This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "a", the home health care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness. **Routine Newborn Care -** If expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to: 1. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother; 2. Inpatient Physician visits for routine examinations and evaluations; 3. Charges made by a Physician in connection with a circumcision; 4. Routine laboratory tests; 5. Postpartum home visits prescribed for a newborn; 6. Follow-up office visits for the newborn subsequent to discharge from a Hospital

Consultant Physician Services - When requested and approved by the attending Physician.

Accidental Injury Dental Treatment for Insured Person's over age 18 - As the result of Injury. Routine dental care and treatment are not payable under this benefit.

Sickness Dental Expense Benefit for Insured Person's over age 18 - If, by reason of Sickness, an Insured Person requires treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred for the treatment.

Student Health Center/Infirmary Expense Benefit - If an Insured Student incurs expenses as the result of treatment at a Student Health Center/Infirmary, we will pay the expenses incurred. Benefits will not to exceed the amount shown in the Schedule of Benefits.

Sports Accident Expense Benefit – We will pay the expenses incurred by an Insured Student as the result of covered sports accident while at play or practice of intramural or club sports as shown in the Schedule of Benefits.

Abortion Expense - We will pay the charges for the expense of a voluntary, non-therapeutic, abortion. This benefit will be in lieu of all other Policy benefits and may not exceed the benefit shown in the Schedule of Benefits.

Bedside Visits (International Students and/or their Dependents Only) - If the Insured Person is Hospital Confined for more than seven (7) continuous days as the result of a Covered Injury or Covered Sickness, We will pay a benefit. We will pay for the cost of an economy round-trip airfare for an individual to travel to the Hospital bedside of the Insured Person. The benefit will not to exceed the amount shown in the Schedule of Benefits. This individual must be designated by the Insured Person and the trip must be approved by Us. No more than one trip may be made during any one Policy Year.

Medical Treatment Received in Home Country (International Students and/or their Dependents Only) - If the Insured Person incurs expenses as the result of treatment for a Covered Injury or Covered Sickness in his or her Home Country, we will pay the expenses incurred not to exceed the amount shown in the Schedule of Benefits.

Medical Evacuation and Repatriation - To be eligible for this benefit, a Student must: a) be an International Student enrolled in the authorized college or school during the period for which coverage is purchased. or b) be a Eligible Domestic Student participating in a study abroad program sponsored by the College or School. An eligible **International Student** must meet the definition of same. An International Student may also enroll his or her Dependent under this Section by payment of additional premium. As used in this Section, an **Eligible Domestic Student** means a permanent resident of the United States who is enrolled at the college or school and who is temporarily participating in international educational activities outside their Home Country. The maximum combined benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits. ***Medical Evacuation Expense –*** If: 1. an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness; 2. that occurs while he or she is covered under this Policy, We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or the Insured Person's Home Country. Benefits will not exceed the specified benefit

shown in the Schedule of Benefits. Payment of this benefit is subject to the following conditions: 1. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five or more consecutive days immediately prior to medical evacuation; 2. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation; 3. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable; 4. No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person's insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination; 5. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and 6. Transportation must be by the most direct and economical route. ***Repatriation Expense-*** If the Insured Person dies while he or she is covered under this Policy, We will pay a benefit. The benefit will be the necessary Usual and Reasonable charges for preparation, including cremation, and transportation of the remains to the Insured Person's place of residence in his or her Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Sleep Studies - We will pay benefits for one Medically Necessary sleep study in an Insured Person's lifetime to determine a sleep disorder. The test must be ordered by a Physician and performed in an appropriately licensed or certified facility.

Allergy Testing – We will pay benefits for allergy testing when Medically Necessary up to the limits shown in the Schedule of Benefits.

Lead Screening - We will pay benefits for an annual lead screening test for each covered Dependent child age nine to thirty-five months of age, inclusive, as required under Connecticut law.

Cardiac Rehabilitation – We will pay benefits for cardiac rehabilitation ordered and supervised by a Physician for Inured Persons recovering from heart attacks, heart surgery and percutaneous coronary intervention (PCI) procedures such as stenting and angioplasty.

Pediatric Dental Care - We will pay the Usual and Reasonable expenses incurred for the following dental care services for Insured Persons up to age 19.

Emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

1. Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
2. Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
3. Sealants on unrestored permanent molar teeth; and

4. Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:

1. Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
2. X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
3. Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
4. In-office conscious sedation;
5. Amalgam, composite restorations and stainless steel crowns; and
6. Other restorative materials appropriate for children.

Endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

Prosthodontic services as follows:

1. Removable complete or partial dentures, including six (6) months follow- up care; and
2. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not covered unless they are required:

1. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
2. For cleft palate stabilization; or
3. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

1. Rapid Palatal Expansion (RPE);
2. Placement of component parts (e.g. brackets, bands);
3. Interceptive orthodontic treatment;
4. Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
5. Removable appliance therapy; and
6. Orthodontic retention (removal of appliances, construction and placement of retainers).

Pediatric Vision Care - We will pay the Usual and Reasonable expenses incurred for emergency, preventive and routine vision care for Insured Persons up to age 19.

Vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

1. Case history;
2. External examination of the eye or internal examination of the eye;
3. Opthalmoscopic exam;
4. Determination of refractive status;
5. Binocular distance;
6. Tonometry tests for glaucoma;
7. Gross visual fields and color vision testing; and
8. Summary findings and recommendation for corrective lenses.

Prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new frames more frequently, as evidenced by appropriate documentation.

Adult Vision Care - We will pay the Usual and Reasonable expenses incurred for an annual retina exam for an Insured Person diagnosed with glaucoma or diabetic retinopathy. We will also pay for one corneal pachymetry test in an Insured Person's lifetime.

MANDATED BENEFITS FOR CONNECTICUT

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

Accidental Ingestion or Consumption of a Controlled Drug: We will pay the Usual and Reasonable expenses incurred due to Medically Necessary inpatient and outpatient emergency medical care arising from accidental ingestion or consumption of a controlled drug, as defined by subdivision (8) of section 21a-240. We will pay the Accidental Ingestion/Consumption of Controlled Drugs Benefit shown in the Schedule of Benefits.

Ostomy Surgery Benefit. We will pay the Usual and Reasonable expenses incurred Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. Benefits are payable up to the limits shown in the Schedule of Benefits. **Ostomy** includes colostomy, ileostomy and urostomy.

Mental Health Conditions Expense Benefit: Usual and Reasonable expense incurred for treatment of a Mental Health Condition on the same that We would pay for any other Covered Sickness. In the case of benefits payable for the services of a licensed Physician or psychiatrist, benefits are also payable for the same services when rendered by the following practitioners or facilities qualified and licensed in accordance with the requirements of Chapter 38A Section 488A of the Connecticut General Laws: Psychologist, Clinical social worker, Marital and family therapist, Alcohol and drug counselor, Professional counselor, Child guidance clinic or residential treatment facility, Residential treatment facility; and Nonprofit community mental health center. **Inpatient Mental Health Conditions** - If an Insured Person requires treatment for mental and nervous disorders during Hospital Confinement, We will pay the Usual and Reasonable expense incurred on the same basis as for any other Covered Sickness. **Partial Hospitalization** - Partial Hospitalization means continuous treatment consisting of not less than four (4. hours and not more than twelve (12) hours in any 24-hour period under a program based in a Hospital or residential treatment facility. Two Partial Hospitalization days may be substituted for one inpatient day in a Hospital or related institution.

Outpatient Mental & Nervous Conditions - When the Insured Person is not Hospital confined, We will pay the Usual and Reasonable expense incurred for outpatient services on the same basis as any other Covered Sickness. This benefit is subject to the Student Health Center Referral requirements.

Autism Spectrum Disorders Benefit: We will pay the Usual and Reasonable expenses incurred for the diagnosis and treatment of Autism Spectrum Disorder on the same basis as any other Covered Sickness. We will provide coverage for the following Medically Necessary treatments, provided such treatments are identified and ordered by a Physician for an Insured Person who is diagnosed with an Autism Spectrum Disorder, in accordance with a treatment plan developed by a Physician pursuant to a comprehensive evaluation or reevaluation of the Insured Person: 1. Behavioral Therapy; 2. Prescription drugs, to the extent prescription drugs are a covered benefit for other Covered Sicknesses, prescribed by a Physician, licensed Physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of Autism Spectrum Disorder; 3. Direct psychiatric or consultative services provided by a licensed psychiatrist; 4. Direct psychological or consultative services provided by a licensed psychologist; 5.Physical therapy provided by a licensed physical therapist; 6. Speech and language pathology services provided by a licensed speech and language pathologist; and 7. Occupational therapy provided by a licensed occupational therapist. For outpatient treatment, we may review the treatment plan, in accordance with Our utilization review requirements, not more than once every six (6) months unless the Insured Person's Physician agrees that a more frequent review is necessary or changes such treatment plan.

Home Health Care Benefit: We will pay the Usual and Reasonable expenses incurred for Home Health Care provided to an Insured Person by a Home Health Care Agency as the result of a Covered Accident or Sickness. Benefits are subject to the following limitations: 1. A $25.00 Home Health Care Deductible; 2. 100 visits in any Policy Year per Insured Person, except in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. (Each visit by a representative of a home health agency shall be considered as one Home Health Care visit; four hours of home health aide service shall be considered as one Home Health Care visit.); and 3. A $200 benefit for Medical Social Services per Policy Year. In order for benefits to be payable, continued hospitalization would otherwise have been required if Home Health Care was not provided, except in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. The plan covering the Home Health Care must be established and approved in writing by such Physician within seven (7) days following termination of a Hospital confinement as a resident inpatient for the same Covered Sickness or Covered Injury for which the Insured Person was hospitalized, except that in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live, such plan may be so established and approved at any time irrespective of whether such Insured Person was so confined or, if such Insured Person was so confined, irrespective of such seven (7) day period. Such Home Health Care must commenced within seven (7) days following discharge, except in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live.

Occupational Therapy Benefit: We will pay the Usual and Reasonable expense incurred as shown in the Schedule of Benefits, for the expenses incurred for Occupational Therapy received by an Insured Person as the result of a Covered Injury or Covered Sickness. For purposes of this Benefit **Health Care Facility** means an institution that provides occupational therapy, including, but not limited to, an outpatient clinic, a Rehabilitative Agency and a skilled or intermediate nursing facility.

Diabetes Treatment Benefit: We will pay the Usual and Reasonable expenses incurred for the Medically Necessary coverage for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage will include laboratory and diagnostic tests for all types of diabetes; Medically Necessary equipment, in accordance with the

Insured Person's treatment plan; and drugs and supplies prescribed by a prescribing Physician. The Outpatient Prescription Drug Expense Benefit limit does not apply.

We will also pay the expenses incurred for the outpatient self-management training for the treatment of diabetes. Such training must be prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. Such training includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training must be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of his or her license. This training benefit will cover: 1. Initial training visits, after an Insured is initially diagnosed with diabetes, that are necessary for the care and management of diabetes including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, total a maximum of ten (10) hours; 2. Training and education that is medically necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Insured Person's symptoms or condition that require modification of his or her program of self-management of diabetes totaling a maximum of four hours; and 3. Training and education that is medically necessary because of the development of new techniques and treatment totaling a maximum for four (4) hours.

Treatment of Lyme Disease: We will pay the Usual and Reasonable expenses incurred for the treatment of Lyme disease. Such treatment will include: 1. Up to thirty (30) days of intravenous antibiotic therapy or sixty (60) days of oral antibiotic therapy, or both; and 2. Further treatment, if recommended by a board certified rheumatologist, infectious disease specialist or neurologist who is licensed in accordance with Connecticut statutes or who is licensed in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of Connecticut.

Hospital Dental Services Benefit: We will pay the Usual and Reasonable expenses incurred for general anesthesia, nursing and related Hospital services provided in conjunction with Inpatient, Outpatient or one day dental services if the following conditions are met: 1. The anesthesia, nursing and related Hospital services are deemed Medically Necessary by the treating dentist or oral surgeon and the Insured's Physician; and 2. The patient is either: a. determined by a licensed dentist, in conjunction with a Physician who specializes in primary care, to have a dental condition of significant dental complexity that the condition requires certain dental procedures to be performed in a Hospital; or b. a person who has a developmental disability, as determined by a Physician who specializes in primary care, that places the person at serious risk. This benefit does not cover the dental procedure.

Mastectomy, Reconstructive Breast Surgery, or Lymph Node Dissection Benefit: Benefits for such surgery will be paid under the Inpatient Surgery Benefit.

Coverage will be provided for at least 48 hours of inpatient care following a mastectomy or lymph node surgery. Coverage will be provided for longer periods of inpatient care if such is recommended by the Insured Person's Physician after conferring with the Insured Person. We will also provide benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a non-diseased breast to produce a symmetrical appearance. Benefits are provided on the same basis as any other Surgical Benefit.

Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices: We will provide coverage for the surgical removal of tumors and the treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of non-dental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors. Benefits will be provided on the same basis as a Covered Sickness except that We will pay the Usual and Reasonable expense incurred in a Policy Year of up to: 1. $500.00 for the surgical removal of tumors; 2. $500.00 for reconstructive surgery; 3. $500.00 for outpatient chemotherapy; 4. $300.00 for prosthesis, except for the purposes of the surgical removal of breasts due to tumors, the annual benefit for prosthesis will be $300.00 for each breast removed; and 5. $1,000.00 for the surgical removal of breast implants.

Pain Management Benefit: We will pay the Usual and Reasonable expenses incurred for an Insured Person for treatment by or under the management of a Pain Management Specialist as required. We will also pay the expenses incurred for Pain treatment ordered by such specialist. Such treatment may include all means necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

Hair Prosthesis Expense Benefit: We will pay the Usual and Reasonable expenses incurred for the cost of a hair prosthesis made necessary for an Insured Person whose hair loss results from chemotherapy treatment when prescribed by a licensed oncologist.

Hypodermic Needles or Syringes Expense Benefit: We will pay the Usual and Reasonable expenses incurred when, by reason of a Covered Injury or Covered Sickness, the Insured Person is prescribed hypodermic needles or syringes by a Physician, for the purpose of administering medications for a covered condition.

Cancer Clinical Trials Expense Benefit: We will pay the Usual and Reasonable expenses incurred for the Routine Patient Care Costs associated with Cancer Clinical Trial s. In order to be eligible for coverage of Routine Patient Care Costs, a Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: 1 One of the National Institutes of Health: or 2. A National Cancer Institute affiliated

cooperative group; or 3. The federal Food and Drug Administration as part of an investigational new drug or device exemption; or 4. The federal Department of Defense or Veterans Affairs. We will not pay benefits for any single institution Cancer Clinical Trial conducted solely under the approval of the institutional review board of an institution or any trial that is no longer approved by one of the four entities identified above. The Insured Person seeking coverage for the Cancer Clinical Trial must provide: 1. Evidence satisfactory to Us that he or she meets all of the patient selection criteria for the Cancer Clinical Trial s, including credible evidence in the form of clinical or pre-clinical data showing that the Cancer Clinical Trial is likely to have a benefit for the Insured Person that is commensurate with the risks of participation in the trial to treat the Insured Person's condition; and 2. Evidence that the appropriate informed consent has been received from the Insured Person; and 3. Copies of any medical records, protocols, test results or other clinical information used by the Physician or institution seeking to enroll the Insured Person in the clinical trial; and 4. A summary of the anticipated Routine Patient Care Costs in excess of the costs for standard treatment; and 5. Information from the Physician or institution seeking to enroll the Insured Person in the clinical trial regarding those items, including any Routine Patient Care Costs, that are eligible for reimbursement by an entity other than Us, including the entity sponsoring the clinical trial; and 6. Any additional information that may be reasonable required for the review of a request for coverage of the Cancer Clinical Trial. We will request any additional information about a Cancer Clinical Trial within five (5) business days of receiving a request for coverage from an Insured Person or a Physician seeking to enroll an Insured Person in such trial. We will NOT provide coverage for Routine Patient Care Costs that are eligible for reimbursement by another entity, including the entity sponsoring the Cancer Clinical Trial.

Infertility Benefit: We will pay the Usual and Reasonable expenses incurred for treatment of Infertility. Such treatment includes, but is not limited to the following services related to Infertility: ovulation induction, embryo transfer, intra-uterine insemination, gamete intra-fallopian transfer, in-vitro fertilization, zygote intra-fallopian transfer, uterine embryo lavage; and low tubal ovum transfer. Coverage under this benefit is limited: 1.to an Insured Student until the date of the student's 40th birthday; 2. for ovulation induction to a lifetime maximum benefit of 4 cycles; 3. for intrauterine insemination to a lifetime maximum benefit of 3 cycles; 4. for lifetime benefits to a maximum of 2 cycles, with not more than 2 embryo implantations per cycle, for IVF, gamete intra-fallopian transfer, zygote intra-fallopian or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward the maximum as 1 cycle; 5. for IVF, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer, to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under the Policy.

Treatment of Inherited Metabolic Diseases and Medically Necessary Specialized Formulas: We will pay the Usual and Reasonable expenses incurred for Amino Acid Modified Preparations and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if: 1. Prescribed as Medically Necessary for the therapeutic treatment of Inherited Metabolic Diseases; and 2. Administered under the direction of a Physician. We will also pay the Usual and Reasonable expenses incurred for Specialized Formulas when such Specialized Formulas are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician. We shall provide coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.

Early Intervention Services Benefit: We will pay the Usual and Reasonable expenses incurred for Medically Necessary early intervention services for Insured Persons. These benefits are available for Insured Persons who are not eligible for Connecticut special education and related services and who are from birth to 36 months of age, inclusive. Such services are needed because a child: 1. Is experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion, in one or more of the following areas: a. Cognitive development; b. Physical development, including vision or hearing; c. Communication development; c. Social or emotional development; or e. Adaptive skills; and 2. Has been diagnosed as having a physical or mental condition that has a high probability of resulting in developmental delay. **Medically Necessary Early Intervention Services** includes those services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment and will include services that enhance functional ability without effecting a cure. Such services include, but are not limited to: 1. Speech and language therapy; 2. Audiology services; 3. Vision services, including evaluation and assessment of visual functioning, referral for medical or other professional services, and communication skills training, orientation and mobility training, and additional training to activate visual motor abilities; 4. Occupational therapy; 5. Physical therapy; 6.Assistive technology services and devices; 7. Medical services only for diagnostic or evaluation purposes; 8. Nursing services, including assessment of health status for purposes of providing nursing care, provision of actual nursing care, administration of medications, treatments, and regimens prescribed by a licensed Physician; 9. Nutrition services, including: a. assessment of nutrition history and dietary intake, anthropometric, biochemical and clinical variables; feeding skills and feeding problems; food habits and food preferences; b. Developing and monitoring appropriate plans to address the nutritional needs of eligible Dependent children; and c. Making referrals to appropriate community resources to carry out nutritional goals; and 10. Psychological and Social Work services, including family training, counseling and home visits. Services covered under the Preventive Services Benefit will be paid under that benefit and not this benefit.

Hearing Aids for Children: We will pay the Usual and Reasonable expenses incurred for the cost of hearing aids for Insured Persons who are age 12 years and younger. Such hearing aids will be considered durable medical equipment under the Policy. The maximum benefit payable for any one child will be limited to the amount shown in the Schedule of Benefits.

Craniofacial Disorders Benefit: We will pay the Usual and Reasonable expenses incurred for the Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Insured Persons 18 years of age and younger. Such processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association, except that no benefit will be paid for Cosmetic Surgery.

Neuropsychological Testing Benefit: We will pay the Usual and Reasonable expenses incurred for Medically Necessary Neuropsychological Testing for an Insured Person who is a Dependent child who is diagnosed with cancer on or after January 1, 2000 when ordered by a Physician to assess the extent of any cognitive or developmental delays in the child due to chemotherapy or radiation treatment.

Isolation Care and Emergency Services Benefit: We will pay benefits for Medically Necessary isolation care and/or emergency services that are provided by the state's mobile field hospital on the same basis as any other Covered Sickness. We will pay the same rates paid under the Medicaid program, as determined by the Connecticut Department of Social Services.

Epidermolysis Bullosa Treatment Benefit: We will pay the Usual and Reasonable expenses incurred for wound care supplies that are Medically Necessary for the treatment of Epidermolysis Bullosa that are administered under the direction of a Physician.

SECTION 5 – EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

The policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the policy.

1. Preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.
2. Dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person's Sound, Natural Teeth or as covered in the Pediatric Dental Benefit.
3. Professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
4. Services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
5. services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental Injury or unless otherwise covered under the Pediatric Vision Benefit.
6. Weak, strained or flat feet, corns, calluses or ingrown toenails.
7. Treatment or removal of nonmalignant moles warts**,** boils, acne, actinic or seborrheic keratosis, dermatofibrosis or nevus of any description or form, hallus valgus repair, or varicosity including the testing for same.
8. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
9. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
10. Any expenses in excess of Usual and Reasonable charges.
11. loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
12. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sports.
14. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
15. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
16. Expenses incurred after:
    - The date insurance terminates as to the Insured Person;
17. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
18. Charges incurred for acupuncture, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
19. Expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.
20. Expenses for radial keratotomy.
21. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    - For the purposes of this provision**,** **Reconstructive Surgery** means

surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    - For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance).
22. Treatment to the teeth, including surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Policy definition of same. This exclusions does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits or to treatment covered under the Pediatric Dental Benefit.
23. an Insured Person's:
    - committing or attempting to commit a felony,
    - being engaged in an illegal occupation, or
    - Participation in a Riot.
24. Elective abortions in excess of the amount shown in the Schedule of Benefits.
25. Congenital defects, except as provided for newborn or adopted children added after the Effective Date of coverage.
26. Custodial care service and supplies.
27. Hernia, of any kind.
28. Expenses that are not recommended and approved by a Physician.

SECTION 6 – CERTIFICATE PROVISIONS

Notice of Claim: Written notice of a claim must be given to Us within 90 days after the date of Injury or commencement of Sickness covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Our authorized agent, with information sufficient to identify the Insured Person will be deemed notice to Us.

Claim Forms: We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss provision.

Proof of Loss: Written proof of Loss must be furnished to Us or to our authorized agent within 90 days after the date of such Loss. If it was not reasonably possible to give written proof in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonable possible. The proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

Time of Payment: Indemnities payable under this Policy will be paid immediately upon receipt of due proof of such Loss.

Payment of Claims: Benefits will be paid to the Insured Person. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to the estate of an Insured Person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any one relative by blood or connection by marriage of the Insured Person who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless the Insured Person directs otherwise, in writing, by the time proofs of loss are filed. We cannot require that the services be rendered by a particular provider.

Physical Examination and Autopsy: We, at Our own expense, will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of death of an Insured Person, We may have an autopsy performed unless prohibited by law.

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

Conformity with State Statutes: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

Assignment: Any portion of any benefits payable for Hospital, nursing, medical or surgical services may, at the Insured Person's option, be paid directly to such Hospital or provider of the service upon authorization by the Insured Person. We do not assume any responsibility for the validity of assignment.

SECTION 7 – APPEALS PROCEDURE

You have the right to appeal any decision or action taken by Us to deny, reduce, or terminate the provision of or payment for health care services requested or received under this Certificate of Insurance. You have the right to have Our decision reviewed by an independent review organization. We must provide you with certain written information, including the specific reason for Our decision and a description of Your appeals rights and procedures every time We make a

determination to deny, reduce, or terminate the provision of or payment for health care services requested or received under the Certificate of Insurance.

External Review Procedure

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

   We shall notify the Insured Person in writing of the Insured Person's right to request an external review at the time the We send written notice of:

   a. An Adverse Determination upon completion of the Our utilization review process described above; or
   b. A final Adverse Determination.

   An external review may be requested within 120 days after the Insured Person receives Our adverse benefit determination. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.
2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person.
3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.
4. We will review the request and if it is:
   a. Complete we will initiate the external review and notify the Insured Person of:
      i. The name and contact information for the assigned independent review organization or the Commissioner of Insurance, as applicable for the purpose of submitting additional information; and
      ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn't apply to expedited request or external reviews that involve an experimental or investigational treatment.
   b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.
5. We will not afford the Insured Person an external review if:
   a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   b. The Insured Person has failed to exhaust Our internal review process; or
   c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

   If We deny a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, We will notify the Insured Person in writing:

   a. The reason for the denial; and
   b. That the denial may be appealed to the Commissioner of Insurance.
6. <u>For an expedited review</u>: the Insured Person may make a request for an expedited external review after receiving an adverse benefit determination if:
   a. The Insured's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time frame of an expedited internal review.
   b. The Insured Person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person, or would jeopardize the Insured Person's ability to regain maximum function, if treated after the time frame of a standard external review. or
   c. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.
7. An Insured Person shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by Us, the insurer.
8. At the request of the independent review organization, the Insured Person, provider, health care facility rendering health care services to the Insured Person, or Us shall provide any additional information the independent review organization requests to complete the review.
9. If the independent review organization does not receive any requested information necessary to complete the review they are not required to make a decision. They shall notify the Insured Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means.
10. We may elect to cover the service requested and terminate the review. We shall notify the Insured Person and all other parties involved with the decision by mail, or with the consent or approval of the Insured Person, by electronic means.
11. In the case of an expedited review, the independent review organization shall issue a written decision within seventy-two (72) hours after being assigned an expedited external review. In all other cases, written decision shall be issued no later than thirty (30) days after the filing of the request for review

to the Insured Person, the insurer and the Insured Person's provider or the health care facility if they requested the review. The written decision shall include a description of the Insured Person's condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

12. We shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the Insured Person's policy or certificate.

External Review of Denial of Experimental or Investigative Treatment

Within 120 days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or the Insured Person's authorized representative may file a request for external review with the Commissioner of Insurance.

An Insured Person or the Insured Person's authorized representative may make an oral request for an external review of the Adverse Determination or final Adverse Determination if the Insured Person's treating Physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

Upon receipt of a request for an expedited external review, the Commissioner of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Commissioner of Insurance immediately shall notify and send a copy of the request to Us. For an expedited external review request, at the time We receive the notice, We or Our designee utilization review organization shall provide or transmit all necessary documents and information considered in making the Adverse Determination or final Adverse Determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540 or Toll Free (800) 633-7867
www.chpstudent.com
Group Number: S200595

Service Representative:
Bailey Agencies, Inc.
15 Thames Street, Suite 100
Groton, CT 06385
Telephone (860) 326-3085
Email: www.baileyagencies.com

Underwritten by:
National Guardian Life Insurance Company
as policy form # NBH-280 (2014) CT.

Certain benefits in this plan are subject to Insurance Department Approval.

Administered by:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800-633-7867
www.chpstudent.com

For a copy of the Company's privacy notice you may:
go to:
www.chpstudent.com
or
Request one from the Health office at your school
Or
Request one from:
Commercial Travelers Mutual Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502
(Please indicate the school you attend with your written request.)

Note: The time you were covered under this plan may count as creditable coverage under State and Federal Law if you leave this plan and go to an employer's plan within 63 days thereafter. You are eligible to receive a certification from the Company regarding the periods you were covered. Please contact the Local Administrator listed in this brochure when you need such certification.

Representations of this plan must be approved by Us.

IMPORTANT

THIS CERTIFICATE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE AS DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE AT THE COLLEGE.

National Guardian® Life Insurance Company
It's about people.

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-0826

The Policy to which this rider is attached is amended as follows:

BENEFIT PAYMENT FOR NETWORK PROVIDERS AND NON-NETWORK PROVIDERS RIDER

This Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. This Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits included in this Rider.

SECTION I – DEFINITIONS is amended by the addition of the following definitions:
Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.
Non-Network Providers have not agreed to any pre-arranged fee schedules.
PPO Allowance means the amount a Network Provider will accept as payment in full for Covered Medical Expenses.

SECTION IV - DESCRIPTION OF BENEFITS is amended as follows:
The provision entitled Treatment of Covered Injury or Covered Sickness is amended to read:

Treatment of Covered Injury or Covered Sickness

We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to a Covered Injury or Covered Sickness. Benefits payable are subject to:

1. Any specified benefit maximum amounts;
2. Any Deductible amounts;
3. Any Coinsurance amount;
4. Any Copayments;
5. The Maximum Out-of-Pocket Expense Limit; and
6. Use of a Network Provider, if any.

The following provision is added:

Preferred Provider Organization

If an Insured Person uses a Network Provider, this Policy will pay the Coinsurance percentage of the PPO Allowance shown in the Schedule of Benefits for Covered Medical Expenses

If a Non-Network Provider is used, this Policy will pay the percentage of the Usual and Reasonable Covered Medical Expense shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be the responsibility of the Insured Person.

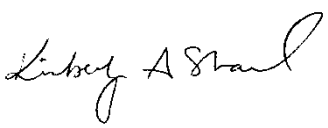
Note, however, that We will pay at the PPO Allowance level for treatment by a Non-Network Provider if:

1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.

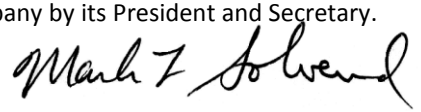
An Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services from a Network Provider does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Physicians are Network Providers each time he or she calls for an appointment or at the time of service.

There are no other changes to the Policy.

This Rider is executed for the Company by its President and Secretary.



Kimberly A. Shaul
Secretary



Mark L. Solverud
President

SCHEDULE OF BENEFITS

Benefit Period: When an Insured Person receives initial medical treatment within 30 days of the occurrence of a Covered Injury or at the onset of a Covered Sickness, eligible benefits will be provided for a continuous Benefit Period. The Benefit Period begins:

1. On the date of occurrence of such Covered Injury; or
2. From the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of:

   ☒ the Policy Term (+ Extension of Benefits – when appropriate)

Preventive Services:

Network Provider: The Deductible, Coinsurance, or Copayment are not applicable to Preventive Services. Benefits for services provided by a Network Provider are paid at 100% of the PPO Allowance.

Non-Network: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum.

Deductible:

Network	$300 Individual/ $900 Family
Non-Network	$600 Individual/$1,800 Family

Out-of-Pocket Expense Limit:

Network	$6,850 Individual/$13,700 Family
Non-Network	No limit

Coinsurance:

Network	80% of PPO Allowance (PA) of Covered Medical Expenses
Non-Network	60% of Usual & Reasonable (U&R) Medical Expenses

PREFERRED PROVIDER ORGANIZATION: To locate a Network Provider in Your area, consult Your Provider Directory or call toll free **1-800-633-7867** or visit Our website at: www.chpstudent.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER OR NOT THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK PROVIDER.**

BENEFITS FOR COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Inpatient Benefits		
Hospital Room & Board Expenses	The PPO Allowance stated above	The Coinsurance Amount shown above
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	The PPO Allowance stated above	The Coinsurance Amount shown above
Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	The PPO Allowance stated above	The Coinsurance Amount shown above
Preadmission Testing	The PPO Allowance stated above	The Coinsurance Amount shown above
Physician's Visits while Confined	The PPO Allowance stated above	The Coinsurance Amount shown above
Inpatient Surgery:		
Surgeon Services	The PPO Allowance stated above	The Coinsurance Amount shown above
Anesthetist	The PPO Allowance stated above	The Coinsurance Amount shown above
Assistant Surgeon	The PPO Allowance stated above	The Coinsurance Amount shown above
Registered Nurse Services for private duty nursing while confined	The PPO Allowance stated above	The Coinsurance Amount shown above
Physical Therapy (inpatient)	The PPO Allowance stated above	The Coinsurance Amount shown above
Skilled Nursing/Rehabilitation Facility Expense Benefit for up to 90 days per Policy Year	The PPO Allowance stated above	The Coinsurance Amount shown above

Outpatient Benefits		
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	The PPO Allowance stated above The PPO Allowance stated above The PPO Allowance stated above	The Coinsurance Amount shown above The Coinsurance Amount shown above The Coinsurance Amount shown above
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	The PPO Allowance stated above	The Coinsurance Amount shown above
Physical Therapy/Occupational Therapy/Speech Therapy (outpatient)	The PPO Allowance stated above $20 Copayment per visit, then 100% of PPO Allowance (Deductible waived)	The Coinsurance Amount shown above
Emergency Services Expenses	$150 Copayment, then 100% of PPO Allowance (Deductible waived)	The greater of: 1. The In-Network Benefit; 2. 80% of the Usual and Reasonable Charge; or 3. The amount Medicare would reimburse
In Office Physician's Fees including Chiropractic care	100% of PPO Allowance $20 Copayment (Deductible waived)	The Coinsurance Amount shown above $0 copayment (deductible waived)

Outpatient Facility Fee	The PPO Allowance stated above	The Coinsurance Amount shown above
Diagnostic X-ray Services	The PPO Allowance stated above	The Coinsurance Amount shown above
Laboratory Procedures (Outpatient**)**	The PPO Allowance stated above Deductible waived	The Coinsurance Amount shown above
Shots and Injections unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Prescription Drugs Prescription should be filled at a participating pharmacy	100% of U&R, subject to: $5 Generic Copayment $40 Preferred Brand Copayment $60 Brand Copayment	The Coinsurance Amount shown above
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The PPO Allowance stated above	The Coinsurance Amount shown above
Other Benefits		
Ambulance Service – Air and Ground	The lesser of: (1) billed charges, or; (2) the rate established by the Connecticut Dept. of Public Health.	The greater of: 1. The In-Network Benefit; 2. 80% of the Usual and Reasonable Charge; or 3. The amount Medicare would reimburse
Braces and Appliances	The PPO Allowance stated above	The Coinsurance Amount shown above
Durable Medical Equipment	The PPO Allowance stated above	The Coinsurance Amount shown above
Hospice Care (Inpatient and Outpatient) For up to 6 months per Policy Year	The PPO Allowance stated above	The Coinsurance Amount shown above

Maternity Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Routine Newborn Care	Same as any other Covered Sickness.	Same as any other Covered Sickness
Consultant Physician Services – when requested by a physician	100% of Coinsurance Amount shown above after Deductible	The Coinsurance Amount shown above
Accidental Injury Dental Treatment for Insured Person's over age 18 subject to $250 per tooth maximum	The PPO Allowance stated above	The Coinsurance Amount shown above
Sickness Dental Expense for Insured Person's over age 18	The PPO Allowance stated above	The Coinsurance Amount shown above
Student Health Services/Infirmary Expense	100% of Usual & Reasonable Charges Deductible waived Pharmacy Copayments apply	
Sports Accident Expense - incurred as the result of the play or practice of intramural or club sports	Same as any other covered condition	Same as any other covered condition
Abortion Expense up to $1,000.00 per Policy Year	The PPO Allowance stated above	The Coinsurance Amount shown above
Bedside Visits (International Students and/or their Dependents Only)	100% of actual charge up to $5,000 maximum per Policy Year	
Medical Treatment Received in Home Country (International Students and/or their Dependents Only)	The PPO Allowance stated above	The Coinsurance Amount shown above.
Medical Evacuation Expense - (International Students and/or their Dependents and Domestic Student participating in a study abroad program)	100% of Actual Charge	

Repatriation Expense - (International Students and/or their Dependents and Domestic Student participating in a study abroad program)	100% of Actual Charge	
Sleep Studies One test in a lifetime	The PPO Allowance stated above	The Coinsurance Amount shown above
Allergy Testing	The PPO Allowance stated above	The Coinsurance Amount shown above
Lead Screening Up to the limit described in the benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Cardiac Rehabilitation	The PPO Allowance stated above	The Coinsurance Amount shown above
Pediatric Dental Care For one dental exam every 6 months	100% of PPO Allowance for Preventive Services	The Coinsurance Amount shown above for Preventive Services
Pediatric Vision Care For 1 pair of prescribed lenses and frames per Policy Year	100% PPO Allowance for Preventive Services	The Coinsurance Amount shown above for Preventive Services
Adult Vision Care Up to the limit described in the benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Voluntary Sterilization Benefit for Males	The PPO Allowance stated above	The Coinsurance Amount shown above
Gender Dysphoria Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Mandated Benefits		
Accidental Ingestion/Consumption of Controlled Drugs Benefit For up to 30 days of Hospital Confinement in a Policy Year	The PPO Allowance stated above	The Coinsurance Amount shown above
Ostomy Surgery and Supplies Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Mental Health Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Autism Spectrum Disorders Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness

Home Health Care Benefit Subject to limits described in the Benefit and subject to $25 Home Health Care Deductible;	The greater of The PPO Allowance stated above or 75%	The Coinsurance Amount shown above
Occupational Therapy Benefit:	The PPO Allowance stated above	The Coinsurance Amount shown above
Diabetes Treatment Benefit	Same as any other Covered Sickness	The Coinsurance Amount shown above
Lyme Disease Subject to the limits described in the Benefit	Same as any other Covered Sickness	The Coinsurance Amount shown above
Hospital Dental Services Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Mastectomy, Reconstructive Breast Surgery, or Lymph Node Dissection Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Pain Management Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Hair Prosthesis Expense Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Hypodermic Needles or Syringes Expense Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Cancer Clinical Trials Expense Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Infertility Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Treatment of Inherited Metabolic Diseases and Medically Necessary Specialized Formulas	Same as any other Outpatient Prescription Drug	Same as any other Outpatient Prescription Drug
Early Intervention Services Benefit	Same as any other Preventive Service	Same as any other Preventive Service
Hearing Aids - one hearing aid every 24 months	The PPO Allowance stated above	The Coinsurance Amount shown above
Craniofacial Disorders Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Neuropsychological Testing Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above

Isolation Care and Emergency Services Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above
Epidermolysis Bullosa Treatment Benefit	The PPO Allowance stated above	The Coinsurance Amount shown above

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum for Double Dismemberment or Loss of Life $10,000.00
½ Principal Sum for Single Dismemberment.....$5,000.00

Loss must occur within 365 days of the date of a covered Accident.

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

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RIDER

The Policy/Certificate to which this Rider is attached is amended as follows:

1. All references to Student Health Center (SHC) are changed to Student Health Service (SHS).
2. The DEFINITIONS section is amended as described below.
   The following new definition is added:
   Gender Dysphoria means a conflict between an Insured Person's physical gender and the gender with which he or she identifies. The identity conflict must continue over at least 6 months and the Insured Person must meet the definition of Gender Dysphoria as described by the American Psychiatric Association.

   The definition of Elective Treatment is deleted in its entirety. It is replaced with the following:

   Elective Treatment includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to, breast reduction, sub-mucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.
3. The DESCRIPTION OF BENEFITS section is amended as described below.
   The following is added to the end of the Emergency Services Expenses benefit:
   If Emergency Services are provided to the Insured Person by a Non-Network Provider, the provider may bill Us directly. We will reimburse the provider the greatest of the following amounts:
   a. The benefit amount We would have paid if the services had been provided by a Network provider;

   b. The Usual and Reasonable rate for such services; or
   c. The amount Medicare would reimburse for such services.

   As used in this benefit, Usual and Reasonable means the eightieth percentile of all charge for the service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc. The contact information for FAIR Health, Inc. is:

   FAIR Health, Inc.
   530 Fifth Avenue, 18th Floor
   New York, NY 10036
   Phone 855-301-3247
   www.fairhealth.org

   The following is added to the end of the Ambulance Services benefit:
   If Ambulance Service is provided to the Insured Person by a Non-Network Provider, the provider may bill Us directly. We will reimburse the provider the greatest of the following amounts:

   d. The benefit amount We would have paid if the services had been provided by a Network provider;
   e. The Usual and Reasonable rate for such services; or
   f. The amount Medicare would reimburse for such services.

   As used in this benefit, Usual and Reasonable means the eightieth percentile of all charge for the service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc. The contact information for FAIR Health, Inc. is:

   FAIR Health, Inc.
   530 Fifth Avenue, 18th Floor
   New York, NY 10036
   Phone 855-301-3247
   www.fairhealth.org

   The Shots and Injections Benefit is deleted in its entirety and replaced with the following:

   9. Shots and Injections – administered in an emergency room or Physician's office and charged on the emergency room or Physician's statement. Allergy serums are included when such serums are administered by an allergist or Physician.

   All references to the Hospice Care Coverage benefit under Outpatient Benefits in the Policy and the Schedule of Benefits are deleted in their entirety.

The following benefits are added to the Other Benefits:

21. **Hospice Care Coverage** for expenses incurred when an Insured Person requires Hospice Care because of a Covered Sickness or Injury. The Insured Person must be diagnosed with a terminal illness by a licensed Physician. The medical prognosis must be death within six months. The Insured Person must elect to receive Palliative rather than curative care. We will not require any more documentation than would be required for the same services under Medicare.

    As used in this benefit:

    Hospice Care means a coordinated program of home and inpatient care provided directly or under the direction of a properly licensed hospice. Such services include palliative and supportive physical, psychological, psychosocial, and other health services to the Insured Person using a medical directed interdisciplinary team.

    Palliative Care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the Insured Person as he or she experiences the stress of the dying process. Palliative care does not include treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

22. **Voluntary Sterilization Benefit** for expenses incurred for voluntary sterilization procedures for males.

23. **Gender Dysphoria Benefit** for expenses incurred for the treatment of Gender Dysphoria. Benefits are subject to the limit shown in the Schedule of Benefits. Covered services include the following:
    a. Counseling by qualified mental health professional;
    b. Hormone therapy, including monitoring of such therapy;
    c. Gender reassignment surgery; and
    d. Genital reconstructive surgery.

    An Insured Person who is a candidate for gender reassignment surgery for treatment of Gender Dysphoria must:
    a. Have referral letters from two qualified mental health professionals;
    b. have experienced well-documented Gender Dysphoria;
    c. have the capacity to make reasoned medical decisions;
    d. be at least 18 years of age;
    e. have addressed and controlled any significant medical or mental health concerns which may affect physical transition; and
    f. have undergone twelve months of continuous hormone therapy, unless the Insured Person has a medical contraindication or is otherwise unable or unwilling to take hormones.

    An Insured Person who is a candidate for genital reconstruction surgery for treatment of Gender Dysphoria must meet the requirements listed above and must have lived for twelve months in a gender role that is congruent with the Insured Person's gender identity.

The **Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices** benefit is deleted in its entirety and replaced with the following:

Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices: We will provide coverage for the surgical removal of tumors and the treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of non-dental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors.

The **Hearing Aids for Children** benefit is deleted in its entirety are replaced with the following:

Hearing Aids: We will pay the Usual and Reasonable expenses incurred for the cost of hearing aids for Insured Persons. Such hearing aids will be considered durable medical equipment under the Policy.

The following is added to the end of the EXCLUSIONS AND LIMITATIONS section:

- Cosmetic procedures related to Gender Dysphoria including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondoplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.

This Rider takes effect with and expires on the same date as the Policy to which it is attached.

There are no other changes to the Policy or Certificate.

In witness whereof We have caused this Rider to be signed by Our President and

Kimberly A. Shaul
Secretary

Mark L. Solverud
President

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AMENDMENT TO DEFINITIONS AMENDMENT

This Amendment makes the revisions listed below to the Policy and Certificate to which it is attached.

The definition of Accident is deleted in its entirety and replaced with the following:
Accident means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

The definition of Covered Injury is deleted in its entirety and replaced with the following:
Covered Injury means a bodily injury that is caused by the Accident directly and independently of all other causes. Coverage under the School's policies must be in force on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

This Amendment is subject to all terms, conditions and provisions of the Policy/Certificate that are not inconsistent with it. Except as stated in this Amendment, it does not change or affect any other terms of the Policy and Certificate.

This Amendment takes effect on the same date as the Policy.

Signed for National Guardian Life Insurance Company, at its Home Office in Madison, Wisconsin.

Kimberly A. Shaul
Secretary

Mark L. Solverud
President

NBH Amend Def

Subject to Insurance Department Approval

CLAIM PROCEDURES

In the event of Injury or Sickness, students should:

1. Report to their Physician, Hospital or Student Health Center.
2. Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim.
3. File claim within ninety (90) days of Injury or first treatment for a Sickness. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

SUBMIT ALL MEDICAL CLAIMS TO:

Cigna
PO Box 188061
Chattanooga, TN 37422-8061
Electronic Payor ID: 62308

Direct all questions regarding benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Consolidated Health Plans.

VALUE ADDED SERVICES

The following services are not part of the Plan Underwritten by National Guardian Life. These value added options are provided by Consolidated Health Plans.

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 *or* if you are in a foreign country, call collect at: 715.295.9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.