Student Health Insurance Plan

Plan Year 17/18

Designed Exclusively for the Students of:
Saint Augustine's University
Raleigh, NC
2017 - 2018

Underwritten by:
National Guardian Life Insurance Company
Madison, WI

Policy Number: 2017I5B11
Group Number: ST0898SH
Effective: 8/1/2017 - 8/1/2018

Administered by:
Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA
Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local Administrative Agency, Consolidated Health Plans, Inc. If you need assistance resolving a complaint, please contact us at: 877-657-5030.

COVERAGE
1. Accident and Sickness coverage begins on August 1, 2017, or the date of enrollment in the plan, whichever is later and ends August 1, 2018.
2. Benefits are payable during the Policy Term, subject to any Extension of Benefits.
3. 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.

See Section II for Termination Dates provision.

EXCESS INSURANCE
The policy is not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim, then the amounts of benefit payable by such other medical insurance will become the deductible amount of the policy if such benefits exceed the deductible amount shown in the Schedule of Benefits.

HEALTH CARE REFORM LAW NOTICE
Your student health insurance coverage is offered by National Guardian Life Insurance Company. Starting January 1, 2014, there are no annual dollar limits for group and individual health insurance coverage of Essential Health Benefits. If you have any questions or concerns about this notice, contact NGL at 800-548-2962. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent’s employer plan or the parent’s individual health insurance issuer for more information.

CERTIFICATE OF STUDENT BLANKET 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) NC (“the Policy”).

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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.
**Adverse Determination** means a determination by Us that an admission, availability of care, continued stay or other health care service that is a Covered Medical Expense has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated. Denials of coverage based on a determination that a service recommended or requested health care or treatment is experimental also are Adverse Determination and must comply with procedures for reviewing coverage denials based on a determination that a recommended or requested health care service or treatment is experimental.

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

**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.

**At Risk for Ovarian Cancer** means either: 1. Having a family history with at least one first-degree relative with ovarian cancer and a second relative, either first-degree or second-degree, with breast, ovarian, or nonpolyposis colorectal cancer; or 2. Testing positive for a hereditary ovarian cancer syndrome.

**Basic Infertility Services** means initial evaluation, semen analysis, laboratory evaluation, evaluation of ovulatory function, postcoital test, endometrial biopsy, pelvic ultra sound, hysterosalpingogram, sono-hystogram, testis biopsy, blood tests and medically appropriate treatment of ovulatory dysfunction. This definition applies to the Infertility Treatment Benefit only.

**BMI (Body Mass Index)** means weight in kilograms divided by height in meters squared.

**Bone Mass Measurement** means a scientifically proven radiologic, radioisotopic, or other procedure performed on a qualified individual to identify bone mass or detect bone loss for the purpose of initiating or modifying treatment.

**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.

**Chemical Dependency** means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

**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.

**Comprehensive Infertility Services** means ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy. This definition applies to the Infertility Treatment Benefit only.

**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, when applicable.

**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.

**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, 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.

**Examinations and Laboratory Tests for the Screening for the Early Detection of Cervical Cancer** means conventional PAP smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

**Gradient Compression Garments** require a prescription, are custom-fit for the Insured Person, and do not include disposable medical supplies such as over-the-counter compression or elastic knee-high or other stocking products.

**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.

**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 rehabilitary care; or 3) Facilities for the aged, drug addicts or alcoholics. Hospital includes duly licensed State tax-supported institutions. The policy shall not exclude payment for charges of a duly licensed State tax-supported institution because of its being a specialty facility for one particular type of illness nor because it does not have an operating room and related equipment for the performance of surgery, but it is not required that benefits be payable for domiciliary or custodial care, rehabilitation, training, schooling, or occupational therapy.
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.

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

Infusion Therapy is the administration of Drugs (prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include drugs administered by aerosol (into the lungs) and by feeding tube.

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 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-dose Screening Mammography means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a Physician’s interpretation of the results of the procedure.

Medically Necessary means those covered services or supplies that are: 1. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under the Clinical Trials Benefit, not for experimental, investigational, or cosmetic purposes; 2. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; 3. Within generally accepted standards of medical care in the community; 4. Not solely for the convenience of the Insured Person, the Insured Person’s family, or the provider. For Medically Necessary services, nothing in this definition precludes Us from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

Morbid Obesity means: a. a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables; b. a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or c. a BMI of 40 kilograms per meter squared without comorbidity.

Organ Donor Search means services related to the search for a living donor for a member recipient.

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

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.

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 a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly licensed physical therapist, a duly licensed clinical social worker, a duly certified substance abuse professional, a duly licensed professional counselor, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, a duly licensed marriage and family therapist, or an advanced practice registered nurse 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.

Prescribed Lenses & Frames means standard prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for a covered Child 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 a covered Child to have new frames more frequently, as evidenced by appropriate documentation. This definition applies to the Pediatric Vision Care Benefit only.
Prostate-Specific Antigen (PSA) tests or Equivalent Tests for the Presence of Prostate Cancer means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

Qualified Individual means any one or more of the following: 1. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass; 2. An individual with radiographic osteopenia anywhere in the skeleton; 3. An individual who is receiving long-term glucocorticoid (steroid) therapy; 4. An individual with primary hyperparathyroidism; 5. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies; 6. An individual who has a history of low-trauma fractures; and 7. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass. This definition applies to the Osteoporosis Coverage/Bone Mass Measurement Benefit only.

Routine Dental Care means dental care provided in the office of a dentist, including: dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt); 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); procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care; In-office conscious sedation; amalgam, composite restorations and stainless steel crowns; and other restorative materials appropriate for children. This definition applies to the Pediatric Dental Care Benefit only.

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

Skilled Nursing Care Facility means a licensed institution devoted to providing medical, nursing, 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.

Specialty Drugs mean prescription drugs which: 1) Are only approved to treat limited patient populations indication or conditions; or 2) Are normally injected, infused or require close monitoring by a Physician or a clinically trained individual; or 3) Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

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.

Surveillance Tests mean annual screening using transvaginal ultrasound and rectovaginal pelvic examination.

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.

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.

Vision Examination means examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will 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: Case history; External examination of the eye or internal examination of the eye; ophthalmoscopic exam; determination of refractive status; binocular distance; tonometry tests for glaucoma; gross visual fields and color vision testing; and summary findings and recommendation for corrective lenses. This definition applies to the Pediatric Vision Care Benefit only.

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
Fulltime students enrolled in 6 or more credit hours are automatically enrolled in this insurance plan, the cost of which will be added to their tuition bill.

Students not wishing to be enrolled in this plan may complete the online waiver demonstrating proof of comparable insurance. A waiver must be submitted for each coverage period.

The Fall waiver deadline is July 25, 2017 and the Spring/Summer waiver deadline is January 15, 2016.

All students must actively attend classes for the first 45 days following their effective date for the term purchased. Except in the case of withdrawal from the College due to Sickness or Injury, any student withdrawing from school during the first 45 days of the period for which he or she is enrolled will not be covered under the Plan and a full refund of premium will be made less any claims paid.

The Company maintains its right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met the Company’s only obligation is to refund premium less any claims paid.

A student who initially waived coverage under the Plan but subsequently experiences an Involuntary Loss of Coverage may elect to enroll for coverage under the Plan within 31 days of the date of Involuntary Loss of Coverage. These students must provide Wells Fargo Insurance with proof of this Involuntary Loss of Coverage (certificate and letter of ineligibility). “Involuntary Loss of Coverage” means that prior coverage has been involuntarily terminated due to no fault of the Covered Student. Such includes coverage that terminates due to loss of employment by spouse or parent. It does not include coverage that has a predetermined termination date; expiration of COBRA eligibility; or coverage that has been voluntarily terminated

Termination Dates: An Insured Person’s insurance will terminate on the earliest of: 1) The date the 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: 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 a minimum of 90 days from the termination date while such confinement continues. 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 a minimum of three months from the Termination date.

Section 3— 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, 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 the Usual and Reasonable Charges for Covered Medical Expenses that are incurred by the Insured Person due to a Covered Injury or Covered Sickness. Benefits payable are subject to: 1) The Maximum Benefit for all Covered Injury and Covered Sickness combined; 2) The Maximum Benefit for all services; 3) Any specified benefit maximum amounts; 4) Any Deductible amounts; 5) Any Coinsurance amount; 6) Any Copayments; 7) The Maximum Out-of-Pocket Expense Limit; 8) the Exclusions and Limitations provision.

**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.

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**Section 3a - SCHEDULE OF BENEFITS – GOLD PLAN**

**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.

**Preventive Services**: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of Usual and Reasonable charge.

**Deductible**: $250

**Out-of-Pocket Expense Limit**: Individual - $6,600

**Coinsurance Amount**: 80% of the Usual and Reasonable charge for Covered Medical Expenses unless otherwise stated below.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION; AND
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS.

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</tr>
<tr>
<td><strong>Rehabilitative Speech Therapy</strong></td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td><strong>Pulmonary Rehabilitation Benefit</strong></td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td><strong>Emergency Services Expenses</strong></td>
<td>The Coinsurance Amount Stated Above Copayment: $250 Copay waived if admitted</td>
</tr>
<tr>
<td><strong>In Office Physician’s Fees</strong></td>
<td>The Coinsurance Amount stated above Copayment: $20</td>
</tr>
<tr>
<td><strong>Primary Care Visit to Treat an Injury or Illness</strong></td>
<td>The Coinsurance Amount stated above Copayment: $20</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>The Coinsurance Amount stated above Copayment: $20</td>
</tr>
<tr>
<td><strong>Other Practitioner Office Visit</strong></td>
<td>The Coinsurance Amount stated above, Copayment: $20</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>The Coinsurance Amount stated above, Copayment: $50</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray Services</strong>, when prescribed by a Physician</td>
<td>The Coinsurance Amount stated above</td>
</tr>
<tr>
<td><strong>Laboratory Procedures</strong>, when prescribed by a Physician</td>
<td>The Coinsurance Amount stated above</td>
</tr>
<tr>
<td><strong>Shots and Injections</strong> unless considered Preventive Services</td>
<td>The Coinsurance Amount stated above</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>The Coinsurance Amount stated above</td>
</tr>
<tr>
<td>BENEFITS FOR COVERED INJURY/SICKNESS</td>
<td>BENEFIT AMOUNT PAYABLE</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Subject to $10 Generic Copayment</td>
</tr>
<tr>
<td></td>
<td>Subject $25 Brand Copayment</td>
</tr>
<tr>
<td></td>
<td>Subject to $25 Specialty Copayment</td>
</tr>
<tr>
<td></td>
<td>Deductible does not apply to Prescription Drugs.</td>
</tr>
<tr>
<td></td>
<td>See Prescription Card.</td>
</tr>
<tr>
<td>Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td></td>
<td>Up to 60 visits per Policy Year.</td>
</tr>
<tr>
<td>Hospice Care Coverage</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Other Benefits</td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment for Insured Person’s over age 18</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Copayment: $75</td>
</tr>
<tr>
<td>Braces and Appliances</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Prosthetic Devices</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Habilitation benefits</td>
<td>The Coinsurance Amount Stated Above</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Pediatric Vision Care Benefit</td>
<td>100% Usual and Reasonable for Preventive Services, limited to 1 visit and 1 pair of prescribed lenses and frames per Policy Year</td>
</tr>
<tr>
<td>Pediatric Dental Care Benefit</td>
<td>See Benefit for limitations</td>
</tr>
<tr>
<td>Diagnostic and Treatment</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Preventive Dental Care</td>
<td>The Coinsurance Amount for Preventive Dental Care is 100%, limited to 1 dental exam every 6 months.</td>
</tr>
<tr>
<td>Minor Restorative Services</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Major Restorative Services</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Endodontic Services</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Periodontal Services</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Prosthodontic Services</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Oral Surgery</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Medically Necessary Orthodontics</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Additional Procedures</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Non-Emergency Medical Treatment Received When Traveling outside the United States</td>
<td>The Coinsurance Amount shown above</td>
</tr>
<tr>
<td>Non-Essential Health Benefits</td>
<td></td>
</tr>
<tr>
<td>Additional Benefits</td>
<td></td>
</tr>
<tr>
<td>Bedside Visits (International Students and/or their Dependents Only)</td>
<td>The Coinsurance Amount stated above</td>
</tr>
<tr>
<td></td>
<td>subject to $1,000 maximum per Policy Year</td>
</tr>
<tr>
<td>Medical Evacuation Expense – (International Students and/or their Dependents)</td>
<td>100% U&amp;R, not to exceed $100,000 per evacuation</td>
</tr>
<tr>
<td>BENEFITS FOR COVERED INJURY/SICKNESS</td>
<td>BENEFIT AMOUNT PAYABLE</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>Repatriation Expense – (International Students and/or their Dependents)</td>
<td>100% U&amp;R, not to exceed $100,000</td>
</tr>
</tbody>
</table>

**Mandated Benefits**

<table>
<thead>
<tr>
<th>Treatments of Bones and Joints of the Jaw, Face, or Head Benefit</th>
<th>Same as any other Covered Sickness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesia and Hospitalization for Dental Procedures Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Diabetes Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Mastectomy Benefit and Reconstructive Breast Surgery</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Clinical Trials Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Mental Illness Benefits</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Diagnosis and Treatment of Lymphedema Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Osteoporosis Coverage/Bone Mass Measurement Benefit</td>
<td>Same as any other Preventive Service</td>
</tr>
<tr>
<td>Colorectal Cancer Screening Benefit</td>
<td>Same as any other Preventive Service</td>
</tr>
<tr>
<td>Coverage for Hearing Aids Benefit</td>
<td>The Coinsurance Amount shown above up to the limits shown in the Benefit</td>
</tr>
<tr>
<td>Mammography and Cervical Cancer Screening Benefit</td>
<td>Same as any other Preventive Service</td>
</tr>
<tr>
<td>Prostate Cancer Benefit</td>
<td>Same as any other Preventive Service</td>
</tr>
<tr>
<td>Required Surveillance Tests for Ovarian Cancer Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Congenital Anomaly Including Cleft Lip/Palate Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Infertility Treatment Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Morbid Obesity &amp; Bariatric Surgery Benefit</td>
<td>Same as any other Covered Sickness and Surgery</td>
</tr>
<tr>
<td>Newborn Hearing Screening Coverage</td>
<td>Same as any other Covered Sickness</td>
</tr>
</tbody>
</table>

Section 3b – Benefit Descriptions

**Essential Health Benefits**

**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.

*Hospital Intensive Care Unit Expense*, including 24-hour nursing care. **This benefit is in lieu of normal Hospital Room & Board Expenses** and 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, and Organ Transplant and Organ Donor Search** – We will pay benefits for inpatient surgery (including pre- and post-operative visits) as specified in the Schedule of Benefits, including Organ Transplants, reconstructive surgery and procedures, internal prosthesis, voluntary male sterilization, and female tubal ligation. 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. Organ Transplants include the following: Hematopoietic stem-cell; cardiac; heart-lung; lung and lobar lung; pancreas; renal; small bowel, small bowel with liver; multi visceral; islet cell; live; donor search; transportation and lodging. Organ transplants do not include investigational transplant services, the purchase price of any organ or tissue, donor services if the recipient is not a member, or services for or related to the transplantation of animal or artificial organs or tissues.

**Registered Nurse’s Services**, when private duty nursing care, while confined, 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 Facility Expense Benefit** - the expenses incurred for the services, supplies and treatments rendered to an Insured Person by a Skilled Nursing Care Facility. The Insured Person must enter a Skilled Nursing Care 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 the policy; and 3. Was for the same or related Sickness or Accident. Services, supplies and treatments by an Skilled Nursing Care 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 for the Skilled Nursing Care 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.

**Cardiac Rehabilitation Benefit** – We will pay Cardiac Rehabilitation benefits for an Insured Person who has been diagnosed with significant cardiac disease, or has suffered a myocardial infarction, or who has undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. Services must be provided at a place of service equipped and approved to provide Cardiac Rehabilitation. We will pay Usual and Reasonable charges incurred for an Insured Person for: 1) Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, Physician’s revision of exercise prescription, and follow up examination for Physician to adjust medication or change regimen; and 2) 90 days each of physical therapy, speech therapy and occupational therapy per contract year for Cardiac Rehabilitation (These therapy benefits for Cardiac Rehabilitation are paid under this benefit, and not under the Therapy Services Benefit.) Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual’s present level of function and prevent regression of that function. Maintenance begins when the therapeutic goads of a treatment plan have been achieved, or when no additional progress is apparent or expected to occur. As used in this benefit: Cardiac Rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling.

**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, including reconstructive surgery, reconstructive prosthesis, voluntary male sterilization, and female tubal ligation. 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: Operating room; Therapeutic services; Oxygen, oxygen tent; Blood and blood plasma; and Miscellaneous supplies.

Outpatient Facility Fee – We will pay the expenses for outpatient facilities, including an ambulatory surgical center, for outpatient surgeries and procedures including: reconstructive procedures, internal prosthesis, and voluntary male sterilization and female tubal ligation.

Outpatient Rehabilitation Visits for Physical Therapy, Occupational Therapy and Chiropractic Care – when prescribed by the attending Physician, for covered sickness or injury, as shown in the Schedule above. We cover chiropractic care when performed by a Doctor of Chiropractic (“Chiropractor”) or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be covered in accordance with the terms and conditions of the policy.

Rehabilitative Speech Therapy – when prescribed by the attending Physician for treatment of a covered injury or sickness, as shown in the Schedule of Benefits above. Speech therapy for stuttering is not covered.

Pulmonary Rehabilitation Benefit - If an Insured Person is diagnosed with significant pulmonary disease, We will pay the Usual and Reasonable charges for one pulmonary rehabilitation program during the Policy Year. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation. Group classes will not be covered.

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.

Primary Care Visit to Treat an Injury or Illness – We will pay for services at a Primary Care Visit such as allergy testing or office surgery. We will not provide coverage under this benefit for drugs that must be administered by a provider.

Specialist Visit - We will pay for services at a Specialist Visit such as: allergy testing or office surgery. We will not provide coverage under this benefit for drugs that must be administered by a provider.

Other Practitioner Office Visit - We will pay for services at Other Practitioner Office Visit such as nurse or Physician’s assistant. We will provide coverage under this benefit for drugs that must be administered by a provider and nutritional counseling for end-stage renal disease (ESRD).

Urgent Care - We will pay the expenses incurred for Urgent Care as shown in the Schedule of Benefits. Urgent Care is medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. If Urgent Care results in an emergency room admission, please follow the instructions for Emergency Services described above.

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.

Infusion Therapy - Infusion Therapy is the administration of Drugs (Prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include Drugs administered by aerosol (into the lungs) and by feeding tube. Covered Expense for Infusion Therapy (including all professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment and training related to Infusion Therapy) will not exceed the Average Wholesale Price as determined by the Insurer or the Negotiated Rate:

Covered Services for Infusion Therapy are as follows:
1. Professional services to order, prepare, compound, dispense, deliver, administer, train or monitor (including clinical pharmacy support) any drugs or other substances used in Infusion Therapy.
2. All necessary supplies and durable medical equipment including, but not limited to, bandages, cotton swabs, intravenous starter kits, tubing, syringes, needles, pump, pole, and electronic monitor.
3. The Infusion Therapy Drugs or other substances.
4. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

**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, including cancer; c. The drug has been recognized for treatment of that condition by one of the following: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; The United State Pharmacopoeia Dispensing Information, volume 1, “Drug Information for Health Care Professionals”; or 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. In addition, for cancer treatment, the drug has been recognized for treatment of that cancer by one of the following: (1) The National Comprehensive Cancer Network Drugs & Biologics Compendium; (2) The Thomson Micromedex Drug Dex; (3) The Elsevier Gold Standard’s Clinical Pharmacology; or (4) Any other authoritative compendia as recognized periodically by the United States Secretary of Health and Human Services. This Includes Contraceptive coverage, drugs or devices that prevent pregnancy and that are approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a Physician authorized to prescribe medications under the laws of this State, for the insertion or removal of and any Medically Necessary examination associated with the use of the Prescribed Contraceptive Drugs or Devices. Prescription drugs or devices required to be covered under this Benefit shall not include: 1) The prescription drug known as "RU-486" or any "equivalent drug product" as defined in G.S. 90-85.27(1); and 2) The prescription drug marketed under the name “Preventative” or any “equivalent drug product” as defined in G.S. 90-85.27(1).

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 above. 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.

An Insured Person cannot refill a prescription until 75% of the supply has been used, except under certain circumstances during a state of emergency or disaster.

**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. Also includes outpatient contraceptive services including consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

**Home Health Care Expense** - We will pay the charges incurred for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary. Benefits for Home Health Care payable under Maternity Benefit will be payable under that Benefit and not this Benefit.

**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 and when necessary air ambulance.

**Accidental Injury Dental Treatment for Insured Person’s over age 18** - Accidental injury of the natural teeth, jaw, cheeks, lips, tongue, roof and floor of the mouth. Congenital deformity, including cleft lip and cleft palate. Removal of tumors, cysts which are not related to teeth or associated dental procedures, exostoses for reasons other than for preparation for dentures.

**Braces and Appliances** - When prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness, including orthotic devices for positional plagiocephaly, of up to a limit of $600 per lifetime.
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.

**Prosthetic Devices** - We will cover the Usual and Reasonable charges incurred for Prosthetic Devices, components of Prosthetic Devices, repairs to Prosthetic Devices, and the training necessary to use these devices. Any requirements of medical necessity or appropriateness applied to this coverage will not be more restrictive than the indications and limitations of coverage and medical necessity established under the Medicare coverage database.

**Chemotherapy and Radiation Therapy** - We will cover the Usual and Reasonable charges for chemotherapy and radiation therapy, as shown in the Schedule of Benefits.

**Habilitation Benefits** – We will pay the Usual and Reasonable charges incurred for health care services that help a person keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

**Maternity Benefit** - We will pay the expenses incurred for maternity charges as follows: 1.) **Prenatal care.** 2.) **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal delivery and 96 hours for caesarean section. If due to complications of pregnancy, provided on the same basis and the same limits as any other Sickness. 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. 3.) **Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child. 4.) **Physician-directed Follow-up Care** including: a. Physician assessment of the mother and newborn; b. Parent education; c. Assistance and training in breast or bottle feeding; d. Assessment of the home support system; e. Performance of any prescribed clinical tests; and f. 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 performed by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are Medically Necessary 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. 5.) **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; and 6. Follow-up office visits for the newborn subsequent to discharge from a Hospital.

**Pediatric Vision Care Benefit:** We will pay the Usual and Reasonable expenses incurred for emergency, preventive, and routine vision care, including one Visual Examination per Policy Year for Insured Students and Dependent Children up to age 19. We will also pay the Usual and Reasonable expenses incurred for one pair of Prescribed Lenses and Frames per Policy Year for Insured Students and Dependent Children up to age 19.

a. 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, including dilation if professionally indicated, 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. Ophthalmoscopic 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.

b. 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.

c. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

**Pediatric Dental Care Benefit:** We will pay the Usual and Reasonable expenses incurred for Routine Dental Care for Insured Students and Dependent Children up to age 19.

**a. Diagnostic and Treatment Services, including:**
(1) Periodic oral evaluation - Limited to 2 during the calendar year;
(2) Limited oral evaluation - problem focused - Limited to 2 during the calendar year;
(3) Oral evaluation for a patient under three years of age and counseling with primary; caregiver - Limited to 2 during the calendar year
(4) Comprehensive oral evaluation - Limited to 2 during the calendar year;
(5) Detailed and extensive oral evaluation - Limited to 2 during the calendar year;
(6) Comprehensive periodontal evaluation - Limited to 2 during the calendar year;
(7) Intraoral - complete set of radiographic images including bitewings limited to 1 every 60 Months;
(8) Intraoral - periapical films and occlusal radiographic image;
(9) Extraoral - radiographic images;
(10) Bitewing - Adult - 1 set once every calendar year / Children - 1 set every six months;
(11) Vertical bitewings - 7 to 8 radiographic images - Adult - 1 set once every calendar year / children - 1 set every six months;
(12) Panoramic radiographic image - once every 60 months;
(13) Caries susceptibility tests; and
(14) Accession of brush biopsy.

**b. Preventive Services, including:**
(1) Prophylaxis - Limited to 2 during the calendar year;
(2) Topical Fluoride – Varnish and topical application of fluoride - Limited to 2 during the calendar year for dependent children up to age 22;
(3) Sealant - per tooth - unrestored permanent molars for dependent children under age 19 - any combination of a sealant or a preventive resin restoration is allowed 1 time per tooth every 24 months;
(4) Preventive resin restorations in a moderate to high caries risk patient - permanent tooth - any combination of a sealant or a preventive resin restoration is allowed 1 time per tooth every 24 months;
(5) Space maintainer - fixed or removable - unilateral or bilateral - Limited to children under age 19; and
(6) Re-cementation of space maintainer - Limited to children under age 19.

**c. Minor restorative services, including:**
(1) Amalgam;
(2) Resin-based composite – anterior (up to three surfaces);
(3) Resin-based composite – four or more surfaces or involving incisal angle (anterior);
(4) Re-cement inlay;
(5) Re-cement crown;
(6) Pre-fabricated porcelain/ceramic crown – primary tooth – under age 15 – limited to 1 per tooth in 60 months;
(7) Prefabricated stainless steel crown - primary tooth – under age 15 – limited to 1 per tooth in 60 months;
(8) Prefabricated stainless steel crown – permanent tooth – under age 15 – limited to 1 per tooth in 60 months;
(9) Protective Restoration; and
(10) Pin retention – per tooth, in addition to restoration.

**d. Major restorative services, including:**
(1) Detailed and extensive oral evaluation – problem focused, by report;
(2) Onlay - metallic - Limited to 1 per tooth every 60 months;
(3) Crown - Limited to 1 per tooth every 60 months;
(4) Core buildup, including any pins - Limited to 1 per tooth every 60 months;
(5) Prefabricated post and core, in addition to crown - Limited to 1 per tooth every 60 months;
(6) Crown repair, by report – Limited to 1 per 12 months;
(7) Inlay Repair or Onlay Repair - Limited to 1 per 12 months;
(8) Veneer Repair – Limited to 1 per 12 months; and
(9) Resin infiltration/smooth surface.

e. **Endodontic services, including:**
   (1) Pulp cap – direct or indirect (excluding final restoration);
   (2) Therapeutic pulpotomy (excluding final restoration);
   (3) Pulpal debridement, primary and permanent teeth;
   (4) Partial pulpotomy for apexogenesis – permanent teeth with incomplete root development;
   (5) Pulpal therapy (resorbable filling) – anterior or posterior, primary tooth (excluding final restoration);
   (6) Anterior root canal, bicuspid root canal, or molar root canal, (excluding final restoration);
   (7) Retreatment of previous root canal therapy – anterior, bicuspid, or molar;
   (8) Apexification/recalcification – initial visit, interim medication replacement, or final visit (apical closure/calcific repair of perforations, root resorption, etc.);
   (9) Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration;
   (10) Pulpal regeneration initial visit, interim visit, completion of treatment;
   (11) Apicoectomy/periradicular surgery;
   (12) Retrograde filling – per root;
   (13) Root amputation – per root; and
   (14) Hemisection (including any root removal) – not including root canal therapy.

f. **Periodontal services, including:**
   (1) Periodontal scaling and root planning - four or more teeth per quadrant - Limited to 1 every 24 months;
   (2) Periodontal scaling and root planning - one to three teeth per quadrant - Limited to 1 every 24 months;
   (3) Periodontal maintenance - 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy;
   (4) Collect - Apply Autologous Product - Limited to 1 in 36 months;
   (5) Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces, per quadrant - Limited to 1 every 36 months;
   (6) Gingivectomy or gingivoplasty – one to three teeth, per quadrant;
   (7) Gingivectomy or gingivoplasty - with restorative procedures, per tooth;
   (8) Gingival flap procedure, including root planning, four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months;
   (9) Gingival flap procedure, including root planning, one to three teeth per quadrant – Limited to 1 every 36 months;
   (10) Clinical crown lengthening – hard tissue;
   (11) Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months;
   (12) Osseous surgery (including flap entry and closure), one to three contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months;
   (13) Surgical revision procedure, per tooth;
   (14) Pedicle soft tissue graft procedure;
   (15) Subepithelial connective tissue graft procedures (including donor site surgery);
   (16) Soft tissue allograft – Limited to 1 every 36 months;
   (17) Combined connective tissue and double pedicle graft, per tooth – Limited to 1 every 36 months;
   (18) Free soft tissue graft procedure;
   (19) Full mouth debridement to enable comprehensive evaluation and diagnosis - Limited to 1 per lifetime; and
   (20) Localized delivery of antimicrobial agents.

g. **Prosthodontic services, including:**
   (1) Adjust complete or partial denture – maxillary or mandibular;
   (2) Repair broken complete denture base;
   (3) Replace missing or broken teeth – complete denture (each tooth);
   (4) Repair resin denture base or framework;
   (5) Repair or replace broken clasp;
(6) Replace broken teeth – per tooth;
(7) Add tooth or clasp to existing partial denture;
(8) Replace all teeth and acrylic on cast metal framework – Limited to 2 in a 24-month period, 6 months after the initial installation;
(9) Rebase complete or partial denture - Limited to 1 in a 36-month period, 6 months after the initial installation;
(10) Reline complete maxillary denture or maxillary partial denture - Limited to 1 in a 36-month period, 6 months after the initial installation;
(11) Reline complete mandibular denture or mandibular partial denture – Limited to 1 in a 36-month period, 6 months after the initial installation;
(12) Tissue conditioning (maxillary or mandibular);
(13) Recement fixed partial denture;
(14) Fixed partial denture repair, by report;
(15) Complete or immediate denture– limited to 1 every 60 months;
(16) Maxillary or Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) - limited to 1 every 60 months;
(17) Maxillary or Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) - limited to 1 every 60 months;
(18) Removable unilateral partial denture-one piece cast metal (including clasps and teeth) - limited to 1 every 60 months;
(19) Endosteal Implant – surgical placement– limited to 1 every 60 months;
(20) Surgical Placement of Interim Implant Body – limited to 1 every 60 months
(21) Mini Implant – limited to 1 every 60 months;
(22) Eposteal Implant – limited to 1 every 60 months;
(23) Transosteal Implant, including hardware – limited to 1 every 60 months;
(24) Implant/Abutment supported removable denture for complete edentulous arch or for partial edentulous arch;
(25) Connecting Bar – implant or abutment supported – limited to 1 every 60 months;
(26) Prefabricated Abutment - includes modification and placement – limited to 1 every 60 months;
(27) Custom fabricated abutment - includes modification and placement – limited to 1 every 60 months;
(28) Abutment supported crown – limited to 1 every 60 months;
(29) Implant supported crown – limited to 1 every 60 months;
(30) Abutment supported retainer for FPD – limited to 1 every 60 months;
(31) Implant supported retainer for FPD – limited to 1 every 60 months;
(32) Implant/abutment supported fixed denture for completely or partially edentulous arch – limited to 1 every 60 months;
(33) Implant Maintenance Procedures – limited to 1 every 60 months;
(34) Repair Implant Prosthesis – limited to 1 every 60 months
(35) Replacement of Semi-Precision or Precision Attachment – limited to 1 every 60 months;
(36) Recement Implant/abutment supported crown or fixed partial denture - limited to 1 every 60 months;
(37) Abutment supported crown - titanium - limited to 1 every 60 months;
(38) Repair Implant Abutment – limited to 1 every 60 months;
(39) Implant Removal – limited to 1 every 60 months;
(40) Debridement of a periimplant defect and surface cleaning of exposed implant surfaces, including flap entry and closure;
(41) Debridement and osseous contouring of a periimplant defect; include surface cleaning of exposed implant surfaces and flap entry and closure;
(42) Bone graft for repair of periimplant defect – not including flap entry and closure or, when indicated, placement of a barrier membrane or biologi materials to aid in osseous regeneration;
(43) Bone graft at time of implant placement;
(44) Implant Index – limited to 1 every 60 months;
(45) Abutment supported retainer crown for FPD - titanium - limited to 1 every 60 months;
(46) Pontic - limited to 1 every 60 months;
(47) Inlay or Onlay - metallic;
(48) Retainer - for resin bonded fixed prosthesis - limited to 1 every 60 months;
(49) Inlay or Onlay - cast predominantly base metal - limited to 1 every 60 months;
(50) Crown - limited to 1 every 60 months;
(51) Occlusal guard, by report - 1 in 12 months for patients 13 and older; and
(52) Unspecified Adjunctive procedure, by report.

h. Oral surgery, including:
(1) Extraction coronal remnants, deciduous tooth;
(2) Extraction, erupted tooth or exposed root (elevation and/or forceps removal);
(3) Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth;
(4) Removal of impacted tooth – soft tissue, partially bony, or completely bony;
(5) Removal of impacted tooth – completely bony with unusual surgical complications;
(6) Surgical removal of residual tooth roots (cutting procedure);
(7) Coronectomy - intentional partial tooth removal;
(8) Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth;
(9) Surgical access of an unerupted tooth;
(10) Alveoplasty in conjunction or not in conjunction with extractions;
(11) Removal of exostosis;
(12) Incision and drainage of abscess – intraoral soft tissue;
(13) Suture of recent small wounds up to 5 cm;
(14) Excision of pericoronal gingiv;
and
(15) Unspecified oral surgery procedure, by report.

i. Medically Necessary orthodontics, including
(1) Limited orthodontic treatment of the primary, transition, or adolescent dentition;
(2) Interceptive orthodontic treatment of the primary or transitional dentition;
(3) Comprehensive orthodontic treatment of the transitional, adolescent, or adult dentition;
(4) Removable appliance therapy;
(5) Fixed appliance therapy;
(6) Pre-orthodontic treatment visit;
(7) Periodic orthodontic treatment visit (as part of contract); and
(8) Orthodontic retention (removal of appliances, construction and placement of retainer(s)).

j. Additional procedures covered as basic services, including palliative treatment of dental pain – minor procedure, consultation (diagnostic service provided by dentist or physician other than requesting dentist or physician), and office visit after regularly scheduled hours.

Non-Emergency Medical Treatment Received When Traveling Outside the United States - If the Insured Person incurs expenses as the result of treatment for a Covered Injury or Covered Sickness in another country, We will pay the Usual and Reasonable expenses incurred not to exceed the amount shown in the Schedule of Benefits.

Non-Essential Health Benefits - Additional 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 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 the 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 the 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.

**Mandated Benefits for North Carolina**

**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.

**Treatments of Bones and Joints of the Jaw, Face, or Head Benefit:** We will pay the Usual and Reasonable expenses incurred for diagnostic, therapeutic, or surgical procedures involving bones or joints of the human skeletal structure as long as the procedure is Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, disease, or traumatic injury. Benefits are payable in the same basis as coverage of procedures involving other bones and joints of the human skeletal structure. Authorized therapeutic procedures for the treatment of conditions of the jaw (temporomandibular joint) shall include splinting and use of intraoral prosthetic appliances to reposition the bones. This benefit does not cover orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.

**Anesthesia and Hospitalization for Dental Procedures Benefit:** We will pay the Usual and Reasonable expenses incurred for payment of anesthesia and Hospital or facility charges for services performed in a Hospital or ambulatory surgical facility in connection with dental procedures for the following Insured Persons: 1. Children below the age of nine (9) years; 2. Persons with serious mental or physical conditions; and 3. Persons with significant behavioral problems, where the Physician treating the Insured Person certifies that, because of the Insured Person’s age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The benefit does not cover the cost of the procedure.

**Diabetes Benefit:** We will pay the Usual and Reasonable expenses incurred for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician or a health care professional designated by the Physician. We shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services. We will cover routine foot care for the treatment of diabetes when it is not palliative or cosmetic.

**Mastectomy Benefit and Reconstructive Breast Surgery:** We will pay the Usual and Customary expenses incurred for a mastectomy performed while an inpatient, including coverage for post-mastectomy inpatient care. The decision to discharge the Insured Person following mastectomy must be made by the attending Physician in consultation with the Insured Person, and shall further ensure that the length of post-mastectomy hospital stay is based on the unique characteristics of each Insured Person taking into consideration the health and medical history of the Insured Person. We will also pay the Usual and Customary expenses incurred for Reconstructive Breast Surgery following a mastectomy. The coverage shall include coverage for all stages and revisions of Reconstructive Breast Surgery performed on a non-diseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphademas. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating Physician. For purposes of this Benefit, **Reconstructive Breast Surgery** means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the non-diseased breast.
**Clinical Trials Benefit:** We will pay the Usual and Reasonable expenses incurred for Medically Necessary Health Care Services provided while an Insured Person is participating in a Covered Clinical Trials. Benefits do not include the costs of services that are not Health Care Services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the Insured Person. In the event a claim contains charges related to services for which coverage is required under this Benefit and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this Benefit, We may deny the claim. As used in this section: **Covered Clinical Trials** means phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that: 1. Involve the treatment of life-threatening medical conditions, 2. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives, and 3. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives. Covered clinical trials must also meet the following requirements: 1. Must involve determinations by treating Physicians, relevant scientific data, and opinions of experts in relevant medical specialties, 2. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities, and 3. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

**Health Care Services** means services provided for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease associated with participation in a Covered Clinical Trial, including those related to health care services typically provided absent a clinical trial, the diagnosis and treatment of complications, and Medically Necessary monitoring, only to the extent that such costs have not been or are not funded by national agencies, commercial manufacturers, distributors, or other research sponsors of participants in clinical trials. This benefit does not cover non-FDA approved drugs provided or made available to an Insured Person who received the drug during a Covered Clinical Trial after the clinical trial has been discontinued.

**Mental Illness Benefit:** We will pay the Usual and Reasonable expenses incurred for Medically Necessary treatment of Mental Illnesses as follows: 1. We will pay for treatment of the following disorders on the same basis as any other Covered Sickness: Bipolar Disorder; Major Depressive Disorder; Obsessive Compulsive Disorder; Paranoid and Other Psychotic Disorder; Schizoaffective Disorder; Schizophrenia; Post-Traumatic Stress Disorder; Anorexia Nervosa; and Bulimia; and 2. We will pay for treatment of other mental illness as diagnosed and defined in the Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, or a subsequent edition published by the American Psychiatric Association, including substance-related disorders (291.0 through 292.2 and 303.0 through 305.9) sexual dysfunction, and Chemical Dependency, except those mental disorders coded in the DSM-IV or subsequent edition as 'V' codes on the same basis as any other Covered Sickness.

We will provide coverage for treatment received in the following: 1. Inpatient units of a general hospital licensed under Article 5 of General Statutes Chapter 131E: a. Chemical dependency units in facilities licensed after October 1, 1984; b. Medical units; c. Psychiatric care units; and 2. Outpatient facilities or programs licensed after July 1, 1984, under Article 2 of General Statutes Chapter 122C: a. Chemical dependency units in psychiatric hospitals; b. Chemical dependency hospitals; c. Residential chemical dependency treatment facilities; d. Social setting detoxification facilities or programs; e. Medical detoxification or programs.

**Diagnosis and Treatment of Lymphedema Benefit:** We will pay the Usual and Reasonable expenses incurred for Medically Necessary for the diagnosis, evaluation, and treatment of lymphedema. Benefits include equipment, supplies, complex decongestive therapy, Gradient Compression Garments, and self-management training and education, if the treatment is determined to be Medically Necessary and is provided by a licensed occupational or physical therapist or licensed nurse that has experience providing this treatment, or other licensed health care professional whose treatment of lymphedema is within the professional's scope of practice.

**Osteoporosis Coverage/Bone Mass Measurement Benefit:** We will pay the Usual and Reasonable expenses incurred for an Insured Person who is a Qualified Individual for scientifically proven and approved Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass. We will only pay for a Bone Mass Measurement every 23 months, unless a Physician determines that a more frequent measurement is Medically Necessary as follows. Conditions under which more frequent Bone Mass Measurement coverage may be Medically Necessary include, but are not limited to: 1. Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months; or 2. Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.
Colorectal Cancer Screening Benefit: We will pay the Usual and Reasonable expenses incurred for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control for colorectal cancer screening, for any nonsymptomatic Insured Person who is: 1. At least 50 years of age; or 2. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control.

Coverage for Hearing Aids: We will pay the Usual and Reasonable expenses incurred for one hearing aid per hearing-impaired ear up to two thousand five hundred dollars ($2,500) per hearing aid every 36 months for Insured Persons under the age of 22 years. The coverage shall include all Medically Necessary hearing aids and services that are ordered by a Physician or an audiologist licensed in this State. Coverage shall be as follows: 1. Initial hearing aids and replacement hearing aids not more frequently than every 36 months; 2. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the covered individual; 3. Services, including the initial hearing aid evaluation, fitting, and adjustments, and supplies, including ear molds.

Mammography and Cervical Cancer Screening Benefit: We will pay the Usual and Reasonable expenses incurred for Examinations and Laboratory Tests for the Screening for the Early Detection of Cervical Cancer and for Low-dose Screening Mammography. Coverage for low-dose screening mammography shall be provided as follows: 1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true the woman has a personal history of breast cancer; the woman has a personal history of biopsy-proven benign breast disease; the woman's mother, sister, or daughter has or has had breast cancer; or the woman has not given birth prior to the age of 30; 2. One baseline mammogram for any woman 35 through 39 years of age, inclusive; 3. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Physician; and 4. A mammogram every year for any woman 50 years of age or older. Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by the North Carolina Medical Care Commission. Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by the North Carolina Advisory Committee on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the Physician's interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by the North Carolina Medical Care Commission.

Prostate Cancer Benefit: We will pay the Usual and Reasonable expenses incurred for Prostate-Specific Antigen (PSA) tests or Equivalent Tests for the Presence of Prostate Cancer when recommended by a Physician.

Required Surveillance Tests for Ovarian Cancer Benefit: We will pay the Usual and Reasonable expenses incurred for Surveillance Tests for female Insured Persons age 25 and older At Risk for Ovarian Cancer.

Congenital Anomaly Including Cleft Lip/Palate Benefit: We will pay the Usual and Reasonable expenses incurred for congenital defects or anomalies specifically including, but not limited to, all necessary treatment and care for Dependent Children born with cleft lip or cleft palate.

Infertility Treatment Benefit: We will pay the Usual and Reasonable expenses incurred for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease, or dysfunction. We will provide coverage for: 1. Basic Infertility Services. Basic Infertility Services will be provided to an Insured Person who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of North Carolina. However, Insured Persons must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Additional tests may be covered if the tests are determined to be Medically Necessary. 2. Comprehensive Infertility Services. If the Basic Infertility Services do not result in increased fertility, We will pay the Usual and Reasonable expenses incurred for Comprehensive Infertility Services. Exclusions and Limitations: a. in vitro, GIFT and ZIFT procedures; B. cost for an ovum donor or donor sperm; c. sperm storage costs; d. cryopreservation and storage of embryos; e. ovulation predictor kits; f. reversal of tubal ligations and reversal of vasectomies; g. all costs for and relating to surrogate motherhood (maternity services are covered for Insured Persons acting as surrogate mothers); h. sex change procedures; i. cloning; j. medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Review, k. all services must be provided by providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.
**Morbid Obesity & Bariatric Surgery Benefit:** We will pay the Usual and Reasonable expenses incurred for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health for the long term reversal of morbid obesity. We will pay these expenses on the same basis as for other medical and surgical procedures.

**Newborn Hearing Screening Coverage:** We shall pay the Usual and Reasonable expenses incurred for newborn hearing screening ordered by the attending Physician pursuant to the newborn screening program.

### Section 4 – 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 and as shown in the Schedule of Benefits.

1. **International Students Only** - expenses incurred within Your Home Country or country of regular domicile.
2. Preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.
3. Routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
4. Medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as provided in the Schedule of Benefits.
5. Treatment to the teeth or dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person’s Sound, Natural Teeth or as otherwise covered under the Preventive Services Benefit as required under federal law.
6. Professional services rendered by an Immediate Family Member or anyone who lives with the Insured Person. Services or supplies not necessary for the medical care of Your Injury or Sickness.
7. Weak, strained, or flat feet, corns, calluses, or ingrown toenails.
8. Diagnostic or surgical procedures in connection with infertility unless such infertility is covered in the Infertility Treatment Benefit.
9. Treatment or removal of nonmalignant moles, warts, boils, acne, actinic or seborrheic keratosis, dermatofibrosis or nevus of any description or form; hallus valgus repair; varicosity; or sleep disorders including the testing for same.
10. Services or supplies for the treatment of an Occupational Injury or Sickness which are paid (or may use 'paid or payable') under the North Carolina Workers’ Compensation.
11. Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina Workers' Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Workers’ Compensation Act.
12. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance, except tax supported institutions, or services provided by Student Health Fees.
13. Any expenses in excess of Usual and Reasonable charges.
14. 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.
15. 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 Insurance Information Schedule.
16. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any intercollegiate, intramural or club sports.
17. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sports;
18. 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.
19. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
20. Expenses incurred after:
   a. The date insurance terminates as to the Insured Person; and
   b. The Maximum Benefit for each Covered Injury or Covered Sickness has been attained; and
c. The end of the Benefit Period specified in the Benefit Schedule.
28. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
29. Charges incurred for acupuncture, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
30. Expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the Policy.
31. Expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a Covered Injury or otherwise covered under the Policy.
32. Racing or speed contests, skin diving, or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
33. 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.
   a. 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.
   b. For the purposes of this provision, cosmetic surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient’s appearance).
34. An Insured Person’s:
   o committing or attempting to commit a felony,
   o being engaged in an illegal occupation, or
   o active participation in a riot.
35. Custodial care service and supplies.
36. Hernia, of any kind.
37. Expenses that are not recommended and approved by a Physician.
38. Elective abortions.

Section 5 – Excess Insurance
We will not pay any hospital, surgical or medical expenses under any provisions to the extent that those same expenses are paid or payable under any of the following plans: Individual, Group, Blanket Franchise Plans, or Union Welfare Plans, including Group Blue Cross and Blue Shield. However, if such expenses remain unpaid after such plans have paid their benefits in full, We will pay such remaining expenses, which are covered under the policy. The same terms of the Policy will apply in paying such remaining expenses. This provision will apply even though the plans named above contain coordination of benefits, non-duplication of benefits or similar provisions.

Section 6 – CLAIM 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 the policy, or as soon thereafter as is reasonably possible. Notice given by You or on Your behalf to Our authorized agent, with information sufficient to identify You will be deemed notice to Us.
Claim Forms: We, upon receipt of a notice of claim, will furnish to You such forms as are usually furnished by Us for filing proofs of loss. If these forms are not given to You within 15 days, the proof of loss requirements are met 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 180 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: We shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:
1. Payment of the claim.
2. Notice of denial of the claim.
3. Notice that the proof of loss is inadequate or incomplete.
4. Notice that the claim is not submitted on the form required by the health benefit plan or by applicable law.
5. Notice that excess insurance information is needed in order to pay the claim.
6. Notice that the claim is pending based on nonpayment of fees or premiums.

We are presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to Our authorized agent or Us or an electronic claim transmitted to Our authorized agent, a designated clearinghouse, or Us on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a Medical Necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through Us which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided, then the specific clinical rationale for the decision is not required under this provision. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, We shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, We shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

If We request additional information and do not receive the additional information within 90 days after the request was made, We shall deny the claim and send the notice of denial to the claimant. We shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. We shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to Our authorized agent or Us within one year after the date of the denial notice closing the claim.

Health benefit plan claim payments that are not made in accordance with this provision shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by Us, interest on health benefit claim payments shall begin to accrue on the 31st day after We received the additional information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope, or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant.

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.
CLAIM PROCEDURE

In the event of accident or sickness, the Insured should:

1. Consult a doctor and follow his/her instructions. Pay the bill and obtain a receipt. Notify the Claims Administrator at:

   Consolidated Health Plans
   2077 Roosevelt Avenue
   Springfield, MA 01104
   877-657-5030
   www.chpstudent.com

   as soon as possible by submitting a Student Insurance Medical Claim Form.

2. Claim forms and instructions on claim procedures are by visiting the website: www.studentplanscenter.com or www.chpstudent.com

3. Written notice of injury or sickness upon which claim may be based must be provided to the Company within ninety (90) days of the date of loss, or as soon thereafter as is reasonably possible.

Section 7 – Internal Appeals, Grievance, and External Review Procedures

The following levels of review are available to Insured Persons or providers who have a complaint, Grievance, or receive an Adverse Determination.

For purposes of this Section, the following definitions apply:

Adverse Determination means a determination by Us that an admission, availability of care, continued stay or other health care service that is a Covered Medical Expense has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated. Denials of coverage based on a determination that a service recommended or requested health care or treatment is experimental also are Adverse Determinations and must comply with procedures for reviewing coverage denials based on a determination that a recommended or requested health care service or treatment is experimental.

Grievance means a written complaint submitted by an Insured Person or their authorized representative acting on the Insured Person’s behalf and with their written consent to represent them. Insured Person in the following paragraphs considers the Insured Person and/or their authorized representative. Grievances may be submitted about any of the following:

1. Our decisions, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a covered person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the certificate of coverage.

2. Claims payment or handling; or reimbursement for services.

3. The contractual relationship between a covered person and an insurer.

4. The outcome of an appeal of a Non-certification under this Appeals Section.

Non-certification means a determination by Our designated utilization review organization or Us that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, or does not meet the prudent layperson standard for coverage of Emergency Services, and the requested service is therefore denied, reduced, or terminated. A Non-certification is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. A Non-certification includes any situation in which We or Our designated agent makes a decision about an Insured Person’s condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision. The levels of review include an Internal Appeal called Formal Review, Grievance Review and Expedited Review.
How to Appeal a Claim Decision – Formal Review

The Formal Review process includes only one level of Internal Appeal. This Formal Review is provided free of charge.

Internal Appeal Formal Review:

1. The Insured Person or his/her provider of service acting on his/her behalf may submit an Internal Appeal for Formal Review within 180 days of the Adverse Determination or denial of benefit coverage.
2. The Insured Person or his/her provider of service must submit the material in writing.
3. Within 3 business days after We receive the request for a Formal Review, We must provide the Insured Person with the name, address and telephone number of the Formal Review coordinator and information on how to submit written material.
4. The Formal Review will enable the Insured Person to review his or her file, to present evidence and testimony as part of the appeals process, and to receive continued coverage pending the outcome of the review.
5. The Insured Person may or may not attend this review but is not required to do so.
6. We will issue a written decision, in clear terms, to the Insured Person and, if applicable, his/her provider of services, within 30 days of the receipt of the Formal Review request. The person or persons reviewing the Internal Appeal will not be the same person or persons who initially handled the matter that is the subject of the Internal Appeal and, if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a Formal Review will contain:
   a. The professional qualifications and licensure of the person or persons reviewing the Internal Appeal.
   b. The name, address, and telephone number of the review coordinator
   c. A statement of the reviewer’s understanding of the Internal Appeal.
   d. A statement of information sufficient to identify the claim including:
      i. The date of the service;
      ii. The health care provider;
      iii. The claim amount (if applicable); and
      iv. Upon request, a statement describing the availability of the diagnosis code and the treatment code and their corresponding meanings.
   e. A statement of the Insured Person’s right to contact the Health Insurance SMART NC for assistance:
      NC Department of Insurance
      Health Insurance Smart NC
      1201 Mail Service Center
      Raleigh, NC 27699-1201
      Phone: 919-807-6860
      Fax: 919-807-6865
   f. The reviewer’s decision in clear terms and the contractual basis or medical rationale in sufficient detail for you to respond further to our position.
   g. A reference to the evidence or documentation used as the basis for the decision.
   h. A statement advising the Insured Person of his/her right to request a Grievance review (second request) and a description of the procedure for submitting a Grievance. A Grievance Review does not allow for benefits or services that are clearly excluded by the policy for quality of care complaints.
7. For Formal Reviews concerning the quality of clinical care delivered by your provider of service, We will acknowledge the Formal Review request within 10 business days. The acknowledgement will advise the Insured Person that:
   a. We will refer the Formal Review request to its quality assurance committee for review and consideration or any appropriate action against the provider of service; and
   b. State law does not allow for a Grievance review for Grievances concerning quality of care.
8. For Formal Reviews concerning prospective and concurrent determinations, We will communicate Our determination to the Insured or his/her provider of services acting on his/her behalf within three business days after Our receipt of all necessary information.

How to Appeal a Claim Decision – Grievance Review:

1. A Grievance review is available to the Insured Person if he/she is dissatisfied with the first level Formal Review decision. The Insured Person or his/her provider of service acting on his/her behalf may submit a Grievance.
2. Within 10 days of the receipt of the request for the Grievance review, We will provide the following information to the Insured:
a. The name, address and telephone number of the Grievance review coordinator.
b. A statement of the Insured Person’s rights, including the right to:
   i. Request and receive from Us all information relevant to the case;
   ii. Present the case to the review panel;
   iii. Submit supporting material prior to and at the review meeting;
   iv. Ask questions of any member of the panel;
   v. Be assisted or represented by a person of the Insured Person’s choosing, including a family member, employer representative or attorney.

3. We will convene a Grievance review panel for each request. The panel will be comprised of persons who were not previously involved in any matter giving rise to the Grievance, are not our employees, and do not have a financial interest in the outcome of the review. A person who was previously involved in the matter may appear before the panel to present information or answer questions.

4. All of the persons reviewing a Grievance involving a non-certification or clinical issue will be providers who have appropriate expertise, including at least one clinical peer. Provided, however, if We have used a clinical peer on an appeal on a Formal Review panel then We may use one of its employees on the Grievance review panel in the same matter if the Grievance review panel comprises three or more persons.

5. The Grievance review meeting will be held within 45 days of receipt of the Grievance review request.

6. The Insured will receive at least 15 days advance notice of the Grievance review meeting date.

7. The Insured will have the right to full review without condition of his/her attendance at the meeting.

8. A written statement of the Grievance review panel’s decision will be issued to the Insured Person within 7 business days after the review meeting. The decision shall include:
   a. The professional qualifications and licensure of the members of the review panel.
   b. A statement of the review panel’s understanding of the nature of the Grievance and all pertinent facts.
   c. The review panel’s recommendation to Us and the rationale behind that recommendation.
   d. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation.
   e. In the review of a clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation.
   f. Our rationale for its decision if it differs from the review panel’s recommendation.
   g. A statement that the decision is Our final determination in the matter.
   h. Notice of the availability of the Commissioner’s office for assistance, including the telephone number and address of the Commissioner’s office.

**Expedited Grievance Review Procedures:**
An expedited Grievance review is available whether or not the initial review was expedited. We may require documentation of medical justification in accordance with NCGS 58-50-61(l). The expedited review can be requested orally or in writing. The Expedited Review does not allow for benefits or services that are clearly excluded by the policy for quality of care complaints.

An expedited Grievance review will meet the requirements for a non-expedited Grievance review with the following differences:
1. The review proceeding must take place and the decision communicated to the Insured Person within 4 business days of receiving all necessary information. All necessary information, including the decision, shall be transmitted by telephone, facsimile, or other available expeditious method.
2. The review meeting must take place via conference call or the exchange of written information. The Insured Person, his/her designated representative, or a provider may contact:

National Guardian Life Insurance Company
School Plans Service Office
70 Genesee Street
Utica, New York 13502
800-756-3702
www.commercialtravelers.com

The Grievance Procedures describe above are voluntary. The North Carolina Department of Insurance is available to assist insurance consumers with insurance related problems and questions. The Insured may inquire in writing to the Department at 1201 Mail Service Center, Raleigh, NC 27699-900 or by telephone at 1-800-546-5664.
How to Appeal a Claim Decision – External Review:
North Carolina law provides for review of Non-certification decisions by an external, Independent Review Organization (IRO). This independent review is only available for Non-certifications. The North Carolina Department of Insurance (NCDOI) administers this service at no charge to an Insured person, arranging for an IRO to review the case once the NCDOI establishes that an Insured Person’s request is complete and eligible for review. An Insured Person or someone he or she has authorized to represent him or her may request an external review. We will notify an Insured Person in writing of his or her right to request an external review each time he or she:
1. receives a Non-certification decision, or
2. receives an appeal decision upholding a Non-certification decision, or
3. receives a Grievance decision upholding the original Non-certification.

In order for an Insured Person’s request to be eligible for external review, the NCDOI must determine the following:
1. that an Insured Person’s request is about a medical necessity determination that resulted in a Non-certification decision;
2. that he or she had coverage with Us in effect when the Non-certification decision was issued;
3. that the service for which the Non-certification was issued appears to be a covered service under an Insured Person’s insurance; and
4. that he or she has exhausted Our internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.
For a standard external review, an Insured Person will be considered to have exhausted the internal review process if he or she has:
1. Where there is just one level of internal review:
   a. completed Our appeal process and received a written determination on the appeal from Us, or
   b. filed an appeal and except to the extent that he or she has requested or agreed to a delay, have not received Our written decision on appeal within 60 days of the date you can demonstrate that you submitted the request, or
   c. received notification that We have agreed to waive the requirement to exhaust the internal appeal process.
2. Where there are two levels of internal review:
   a. completed Our appeal and Grievance review and received a written Grievance determination from Us, or
   b. filed a Grievance and except to the extent that he or she has requested or agreed to a delay, have not received Our written decision within 60 days of the date can demonstrate that a Grievance was filed with Us, or
   c. received notification that We have agreed to waive the requirement to exhaust the internal appeal and/or Grievance process, if applicable.

If an Insured Person’s request for a standard external review is related to a retrospective Non-certification (a Non-certification which occurs after he or she has received the services in question), an Insured Person will not be eligible to request a standard review until he or she has completed Our internal review process and received a written final determination from Us.
If an Insured Person wishes to request a standard external review, he or she (or his or her representative) must make this request to NCDOI within 120 days of receiving Our written notice of final determination that the services in question are not approved. When processing an Insured Person’s request for external review, the NCDOI will require such person to provide the NCDOI with a written, signed authorization for the release of any of an Insured Person’s medical records that may need to be reviewed for the purpose of reaching a decision on the external review.
Within 10 business days of receipt of an Insured Person’s request for a standard external review, the NCDOI will notify an Insured Person and his or her provider of whether an Insured Person’s request is complete and whether it is accepted. If the NCDOI notifies an Insured Person that his or her request is incomplete, he or she must provide all requested additional information to the NCDOI within 150 days of the date of Our written notice of final determination. If the NCDOI accepts an Insured Person’s request, the acceptance notice will include:
1. the name and contact information for the Independent Review Organization (IRO) assigned to an Insured Person’s case;
2. a copy of the information about an Insured Person’s case that We have provided to the NCDOI;
3. notice that We will provide you or an Insured Person’s authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
4. notification that you may submit additional written information and supporting documentation relevant to the initial Non-certification to the assigned IRO within 7 after receipt of the notice of acceptance.

If an Insured Person chooses to provide any additional information to the IRO, he or she must also provide that same information to Us at the same time using the same means of communication (e.g., he or she must fax the information to Us if he or she faxed it to the IRO). When faxing information to Us, send it to 1-315-797-0195. If an Insured Person chooses to mail the information, send it to:

National Guardian Life Insurance Company
School Plans Service Office
70 Genesee Street
Utica, New York 13502
800-756-3702
www.commercialtravelers.com

Please note that an Insured Person may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and Us. The NCDOI will forward this information to the IRO and Us within two business days of receiving an Insured Person’s additional information.

The IRO will send an Insured Person written notice of its determination within 45 days of the date the NCDOI received an Insured Person’s standard external review request. If the IRO’s decision is to reverse the Non-certification, We will, reverse the Non-certification decision within 3 business days of receiving notice of the IRO’s decision, and provide coverage for the requested service or supply that was the subject of the Non-certification decision. If an Insured Person is no longer covered under the Policy at the time We receive notice of the IRO’s decision to reverse the Non-certification, We will only provide coverage for those services or supplies an Insured Person actually received or would have received prior to disenrollment if the service had not been Non-certified when first requested.

An expedited external review of a Non-certification decision may be available if he or she has a medical condition where the time required to complete either an expedited internal appeal or Grievance review or a standard external review would reasonably be expected to seriously jeopardize an Insured Person’s life or health or would jeopardize an Insured Person’s ability to regain maximum function. If he or she meets this requirement, he or she may make a written or verbal request to the NCDOI for an expedited review after such Insured Person:

1. Where there is just one level of internal review:
   a. receive a Non-certification decision from Us AND file a request with Us for an expedited appeal, or
   b. receive an appeal decision upholding a Non-certification decision.

2. Where there are two levels of internal review:
   a. receive a Non-certification decision from Us AND file a request with Us for an expedited appeal, or
   b. receive an appeal decision upholding a Non-certification decision AND file a request with Us for an expedited Grievance review, or
   c. receive a Grievance review decision upholding the original Non-certification.

An Insured Person may also make a request for an expedited external review if he or she receives an adverse Grievance review decision, if applicable or Formal appeal decision concerning a Non-certification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review an Insured Person’s request and determine whether it qualifies for expedited review. An Insured Person and his or her provider will be notified within 3 business days if an Insured Person’s request is accepted for expedited external review. If an Insured Person’s request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if Our internal review process was already completed, or (2) require the completion of Our internal review process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective Non-certifications.

The IRO will communicate its decision to an Insured Person within 4 business days of the date the NCDOI received an Insured Person’s request for an expedited external review. If the IRO’s decision is to reverse the Non-certification, We will, within one day of receiving notice of the IRO’s decision, reverse the Non-certification decision for the requested service or supply that is the subject of the Non-certification decision. If an Insured Person is no longer covered by Our Policy at the time We receive notice of the IRO’s decision to reverse the Non-certification, We will only provide coverage for those services or supplies the Insured Person actually received or would have received prior to disenrollment if the service had not been Non-certified when first requested.

The IRO’s external review decision is binding on the Insured Person and Us, except to the extent the Insured Person may have other remedies available under applicable federal or state law.
He or she may not file a subsequent request for an external review involving the same Non-certification decision for which he or she has already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOI at:

**By Mail:**
NC Department of Insurance  
Health Insurance Smart NC  
1201 Mail Service Center, Raleigh, NC 27699-9001  
(fax) 919-807-6865

**In Person:**  
Dobbs Building  
430 N. Salisbury St.  
1st Floor, Suite 1072  
Raleigh, NC  
(Toll-free in NC) 1-855-408-1212

An Insured Person may also obtain information from Health Insurance SMART NC that will assist him or her with internal claims and appeals and external review processes. He or she should contact:  
North Carolina Department of Insurance  
Health Insurance Smart NC  
1201 Mail Service Center  
Raleigh, NC 27699-1201  
877-885-0231 (toll free)  
919-807-6860  
Fax: 919-807-6865

You have the right to appeal any Adverse Determination, 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.

*Service Representative:*
**Consolidated Health Plans**  
2077 Roosevelt Avenue  
Springfield, MA 01104  
877-657-5030  
[www.chpstudent.com](http://www.chpstudent.com)

*Underwritten by:*
**National Guardian Life Insurance Company**  
As policy form # NBH-280 (2014) NC

National Guardian Life Insurance Company is not affiliated with Guardian Life Insurance Company of America, aka The Guardian or Guardian Life.

*Administered by:*
**Consolidated Health Plans**  
2077 Roosevelt Avenue  
Springfield, MA 01104  
877-657-5030  
[www.chpstudent.com](http://www.chpstudent.com)

*For a copy of the Company’s privacy notice you may go to:*
www.consolidatedhealthplan.com/about/hipaa
or
Request one from the Health office at your school
or
Request one from:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
877-657-5030
www.chpstudent.com
(Please indicate what school you attend with your written request)
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.
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.


Kimberly A. Shaul  
Secretary

Mark L. Solverud  
President

NBH Amend Def

*Subject to Insurance Department Approval*
The following services are not part of the Plan Underwritten by National Guardian Life Insurance Company. These value added options are provided by Consolidated Health Plans.

**VISION DISCOUNT PROGRAM**
For Vision Discount Benefits please go to:
www.consolidatedhealthplan.com/products/davisvision

**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.

**EFFECTIVE DATES AND COSTS**

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<tr>
<td>Student</td>
<td>$1,674</td>
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*The above rates include an administrative fee.

The Policy is renewed as a new policy for the term August 1, 2017 to August 1, 2018 as Policy Number 2017I5B11. All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.