Student Health Insurance Plan

Plan Year 17/18

Designed Exclusively for the Students of:
St. Louis College of Pharmacy
St. Louis, MO
2017 - 2018

Underwritten by:
National Guardian Life Insurance Company
Madison, WI

Policy Number: 20175A95
Group Number: ST0913SH
Effective: 8/1/2017 - 8/1/2018

Administered by:
Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA
WHERE TO FIND HELP

For questions about claims status, eligibility, enrollment and benefits please contact:

CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5030
www.chpstudent.com

HOW DO I WAIVE/ENROLL?

Waiver:

Eligible Students who DO NOT WANT to be enrolled in the Student Health Insurance Program must submit an online Waiver Form documenting proof of comparable coverage in another health insurance plan prior to the posted waiver date.

Recognizing that health insurance situations may change, students will be required to provide proof of comparable coverage each academic year in order to waive participation in the Student Health Insurance Program.

Please note: The Company issuing the policy used to waive inclusion in the Student Health Insurance Program must be wholly based in the United States.

Enrollment:

The students account will be charged for the insurance based on the selected enrollment period. Enrollments will not be accepted if received after the Cut-Off-Dates. Students may enroll their eligible dependents by completing a Dependent enrollment form and mailing it in with their Dependent coverage payment directly to Consolidated Health Plans.

You must meet the Eligibility requirements each time you pay a premium to continue insurance coverage. To avoid a lapse in coverage, your premium must be received within 31 days after the coverage expiration date. It is the student’s responsibility to make timely renewal payments to avoid a lapse in coverage.

EFFECTIVE DATES AND COSTS

The St. Louis College of Pharmacy Student Health Insurance Plan provides coverage to students for a twelve (12) month period – from 12:01 a.m. August 1, 2017, through 12:01 a.m. August 1, 2018.

<table>
<thead>
<tr>
<th></th>
<th>Annual* 08/01/17 – 08/01/18</th>
<th>Fall* 08/01/17 – 01/01/18</th>
<th>Spring* 01/01/18 – 08/01/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$3,667</td>
<td>$1,537</td>
<td>$2,130</td>
</tr>
<tr>
<td>1 Dependent</td>
<td>$3,667</td>
<td>$1,537</td>
<td>$2,130</td>
</tr>
<tr>
<td>2 Dependents</td>
<td>$7,334</td>
<td>$3,074</td>
<td>$4,260</td>
</tr>
<tr>
<td>3 or more Dependents</td>
<td>$11,001</td>
<td>$4,611</td>
<td>$6,390</td>
</tr>
</tbody>
</table>

Dependent rates are in addition to the student rate.

*The above rates include an administrative fee.

Insurance for an Eligible Person who enrolls during the enrollment period established by the school is effective on the latest of the following dates:

1. the Policy Effective Date;
2. the date We receive the completed enrollment form;
3. the date the required premium is paid; and
4. the date the student enters the Eligible Class.

Coverage for a student’s eligible Dependent who enrolls:

1. during the enrollment period established by the Policyholder; or
2. within 31 days after the student acquires a new Dependent; or
3. within 31 days after a Dependent terminates coverage under another Health Care Plan, is effective on the latest of the following dates:
1. the first day of the Coverage Period;
2. the date the student enters the Eligible Class;
3. the date We receive the completed enrollment form; and
4. the date the required premium is paid.

After the time periods described above, the student must wait until the next enrollment period, except for a newborn or a newly adopted child and involuntary loss of coverage under another Health Care Plan.

We will pay benefits for a newborn child of the Insured until that child is 31 days old. Coverage may be continued beyond 31 days if the Insured notifies Us of the child’s birth and pays the required premium, if any.

Adopted children will be covered on the same basis as a newborn child from the date of the child is placed for adoption with the Insured. Coverage will cease on the date the child is removed from placement and the Insured’s legal obligation terminates. An adopted child is one who has not yet attained 18 years of age.

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, Lockton Companies at 314-812-3217, or the Administrative Agency CHP. If You need assistance resolving a complaint, please contact Us at: 877-657-5030.

The Policy is issued as a new policy for the term August 1, 2017 to August 1, 2018 as Policy Number 2017I5A95. All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.

COVERED
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.

Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.

CERTIFICATE OF STUDENT HEALTH INSURANCE POLICY
issued by
NATIONAL GUARDIAN LIFE INSURANCE COMPANY,
Two East Gilman Street, P.O. Box 1191, Madison, WI 53701
(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 PPO (2016) MO (“the Policy”).

Table of Contents
Section 1 — Definitions
Section 2 — Eligibility, Enrollment and Termination
Section 3 — Benefits
Section 4 — Exclusions and Limitations
Section 5 — Claims Procedure
Section 6 — Coordination of Benefits
Section 7 — Appeals Procedure

Section 1 — Definitions
The terms listed below, if used in this Certificate, have the meanings stated.
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.
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.
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.

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, and similar conditions not medically distinct from a difficult pregnancy.

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

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

Covered Injury means a bodily injury that is 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 a Covered Medical Expense.

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; 3. Not in excess of the PPO Allowance; and 4. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

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

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Deductible means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Policy. The amount of the Deductible and the frequency (annual or per occurrence) will be shown in the Schedule of Benefits.

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

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

Elective Surgery includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary Treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include cosmetic surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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.

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 manifests itself by acute symptoms which are sufficiently severe (including severe pain) that causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention to result in: 1. 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; 2. Serious impairment to bodily functions; or 3. Serious dysfunction of any bodily organ or part.

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

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

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitative and Habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

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

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

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

**Hospice Care** means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

**Hospital** means a legally constituted institution (or an institution which operates pursuant to law), having organized facilities for the care and Treatment of sick and injured persons on a resident or inpatient basis, including facilities for diagnosis and surgery under the supervision of a staff of one (1) or more licensed Physicians and which provides twenty-four (24)-hour nursing service by registered nurses on duty or call. It does not mean convalescent, nursing, rest or Extended Care Facilities or facilities operated exclusively for Treatment of the aged, drug addict or alcoholic, even though the facilities are operated as a separate institution by a Hospital.

**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.

**Insured Student** means a student of the Policyholder who is eligible and insured for coverage under the Policy.

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

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

**Medically Necessary** medical Treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. The Insured Person’s health care provider determines if the medical Treatment provided is medically necessary.

**Mental Health Disorder** means a condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Network Providers** are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.
Non-Network Providers have not agreed to any pre-arranged fee schedules.

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 Doctor of Medicine (M.D.); or Doctor of Osteopathy (D.O.); or Doctor of Dentistry (D.M.D. or D.D.S.); or Doctor of Chiropractic (D.C.); or Doctor of Optometry (O.D.); or 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 mean any licensed practitioner of the healing arts who We are required by law to recognize as a “Physician.” This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician’s assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician.

The term Physician does not mean any person who is an Immediate Family Member.

PPO Allowance means the amount a Network Provider will accept as payment in full for Covered Medical Expenses.

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

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

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which: 1. mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury; 2. provides care supervised by a Physician; 3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse; 4. is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and 5. is not a rest, educational, or custodial facility or similar place.

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.

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.

Substance Use Disorder means any condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

Total Disability or Totally Disabled, as it applies to the Extension of Benefits provision, means the Insured Person’s inability, because of Sickness or Injury, to perform the substantial and material duties of his or her regular occupation for a period of at least twelve (12) months, unless the total Benefit Period is less than twelve (12) months. After the initial Benefit Period, Total Disability shall mean the Insured Person’s inability to perform the substantial and material duties of any occupation for which the Insured Person is qualified by education, training or experience.

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

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

We, Us, or Our means National Guardian Life Insurance Company or its authorized agent. Also referred to as the Company.

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

Section 2 – Eligibility, Enrollment and Termination
All domestic students living on the College main campus in St. Louis, MO are automatically enrolled in this insurance plan at registration. The premium for coverage is added to their student account unless proof of comparable coverage has been submitted to the University Student Health Services Insurance Coordinator by the specified deadline date.

All F-1 and J-1 visa international students are automatically enrolled in this insurance plan at the time of registration. International students exempt from this requirement are students that have been sponsored by their government to attend College, or students that have obtained academic sponsorship through an institution. Waiver of the insurance requirement for international students is determined by the Director of the International Services Department. The premium for coverage is added to their student account. Nurse anesthesia students currently enrolled in program courses are eligible and will be automatically enrolled in this insurance plan at registration. See waiver provisions in How Do I Waive/Enroll section.

Undergraduate students with a current enrollment of 9 credit hours per term are eligible and will be automatically enrolled in this insurance plan at registration. See waiver provisions in How Do I Waive/Enroll section.

Domestic graduate student enrollment in the student health insurance plan will be evaluated by the Health Services department based on current academic enrollment. If eligible, graduate students will be automatically enrolled in this insurance plan at registration. See waiver provisions in How Do I Waive/Enroll section.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. The Company maintains its right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium minus any claims paid.

Insured Students who are enrolled in the Student Health Insurance Plan may also enroll their eligible Dependents. Eligible dependents under the plan include the Insured person’s spouse and dependent children.

Students may also enroll their Dependents within thirty-one (31) days of an eligible qualifying event. Eligible qualifying events for a Dependent are defined as birth or marriage (to the Insured Student). Coverage will be effective as of the date of the qualifying event. Enrollment requests (including payments) received after the thirty-one (31) days following the qualifying event will not be accepted.

**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 the 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 and subject to the Grace Period provision. Except for nonpayment of the required premium or the failure to meet continued underwriting standards, We will not terminate the Policy before the first anniversary date of the effective date of the Policy. A notice of intention to terminate the Policy by Us will be given to the Policyholder at least 31 days before the effective date of the termination. Any termination by Us shall be without prejudice to the expenses originating prior to the effective date of termination. An expense will be considered incurred on the date the medical care or supply is received.

**Extension of Benefits:** Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended 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 90 days from the Termination Date while such confinement continues. If the Insured Person is Totally Disabled, the coverage for the condition causing the Total Disability will be extended for up to three months from the Termination Date.

**Section 3 – BENEFITS**

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

**Preferred Provider Organization:** If an Insured Person uses a Network Provider, the Policy will pay the Coinsurance percentage of the PPO Allowance shown in the Schedule of Benefits for Covered Medical Expenses.
If a Non-Network Provider is used, the Policy will pay the percentage of the Usual and Reasonable Covered Medical Expense shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be the responsibility of the Insured Person.

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

1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or

2. there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider. An Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services from a Network Provider does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Physicians are Network Providers each time he or she calls for an appointment or at the time of service.

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

**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. Expenses that are not eligible or amounts above any Maximum Benefit do not apply towards the Out-of-Pocket Expense Limit. However, the Insured Person’s Coinsurance amounts, Deductibles and Copayments will apply toward the Out-of-Pocket Expense Limit.

<table>
<thead>
<tr>
<th>SCHEDULE OF BENEFITS</th>
<th>NETWORK PROVIDER</th>
<th>NON-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>100% of the Usual and Reasonable charge with no Coinsurance, Copayment or Deductible</td>
<td>70% of the Usual and Reasonable charge, Deductible, Coinsurance and Copayment are applicable</td>
</tr>
<tr>
<td>Deductible</td>
<td>$50</td>
<td>$300</td>
</tr>
<tr>
<td>Hospital Inpatient Facility Copayment</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Out-of-Pocket Expense Limit</td>
<td>Individual $2,000/Family $4,000</td>
<td>Individual $6,000/Family $12,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>90% of PPO Allowance for Covered Medical Expenses unless otherwise stated below</td>
<td>70% of Usual and Reasonable Charge for Covered Medical</td>
</tr>
</tbody>
</table>

NBHCert-280 (2016) MO NPPO 8
<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Room &amp; Board Expenses</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room &amp; Board Expenses</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses for services &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Physician’s Visits while Confined</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td><strong>Inpatient Surgery:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Registered Nurse Services for private duty nursing while confined</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Physical Therapy (inpatient)</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Skilled Nursing Facility Expense Benefit Up to 150 days per Policy Year <em>(Hospital Inpatient Facility Deductible Waived)</em></td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
</tbody>
</table>

*Copay applies*
<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Outpatient Facility Fee</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services &amp; supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood &amp; plasma</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Habilitative Services are covered to the extent that they are Medically Necessary. If benefits also payable under the Mandated Early Intervention Services or Autism Benefit for the same service, the benefit will payable only once. The greater benefit will be paid.</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Emergency Services Expenses</td>
<td>90% of PPO Allowance for Covered Medical Expenses Copayment: $100 Deductible waived if admitted</td>
<td>90% of PPO Allowance for Covered Medical Expenses Copayment: $100 Deductible waived if admitted</td>
</tr>
<tr>
<td>In Office Physician’s Visits</td>
<td>100% of PPO Allowance for Covered Medical Expenses Copayment: $20 Deductible Waived</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40 Deductible Waived</td>
</tr>
<tr>
<td>Private Duty Nursing in home</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient Benefits (cont.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Centers or Facilities</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Copayment: $50 Deductible Waived</td>
<td>Copayment: $75 Deductible Waived</td>
</tr>
<tr>
<td>Diagnostic X-ray Services</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Laboratory Procedures (Outpatient)</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Copayment: $15 Copayment: $40 Preferred Brand Copayment: $70 Brand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>See Prescription Card</td>
<td></td>
</tr>
<tr>
<td>Outpatient Miscellaneous Expense</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>for services not otherwise covered but excluding surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Up to 100 visits per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care Coverage</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Dialysis Treatment</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Other Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Durable Medical Equipment and Prosthesis</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Consultant Physician Services</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment for Insured Persons</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>90% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>over age 18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickness Dental Expense for Insured Persons over age 18</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>90% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
</tbody>
</table>
### BENEFITS PER COVERED INJURY/SICKNESS

<table>
<thead>
<tr>
<th>Other Benefits (cont.)</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Evacuation Expense –</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Repatriation Expense –</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Pediatric Dental Care Benefit</td>
<td>See Benefit for limitations</td>
<td>See Benefit for limitations</td>
</tr>
<tr>
<td>Preventive Dental Care - limited to 1 dental exam every 6 months</td>
<td>100% of PPO Allowance for Covered Medical Expenses for Preventive Services</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses for Preventive Services</td>
</tr>
<tr>
<td>The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Dental</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Clinical Oral Evaluations</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Endodontic Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Periodontal Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Prosthodontic Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Medically Necessary Orthodontic Care</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Pediatric Vision Care Benefit</td>
<td>100% of PPO Allowance for Covered Medical Expenses for Preventive Services</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses for Preventive Services</td>
</tr>
<tr>
<td>Limited to 1 visit per Policy Year and 1 pair of prescribed lenses and frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Subject to a maximum number of visits of 26 per Policy Year, then prior approval after the 26th visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment for Temporomandibular Joint (TMJ) Disorders</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hearing Aids (newborn)</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>90% of PPO Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
</tbody>
</table>

### MANDATED BENEFITS

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Trials Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Early Intervention Services Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Enteral Formula Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Dental Anesthesia Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Low-Dose Mammography Screening</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Treatment of Breast Cancer Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Reconstructive Surgery Following Mastectomy Benefit</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>MANDATED BENEFITS (cont.)</td>
<td></td>
</tr>
<tr>
<td>Autism Treatment Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Second Opinion for Cancer Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Leukocyte Antigen Testing Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Oral Chemotherapy Benefit</td>
<td>Same on same basis as other intravenously administered or injected cancer medications, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Diabetes Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Telehealth Services</td>
<td>On the same basis as an In Office Physician’s Visit Benefit</td>
</tr>
</tbody>
</table>

Inpatient Benefits

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

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

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

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

**Physical Therapy while Confined** when prescribed by the attending Physician.

**Skilled Nursing Facility Expense Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for custodial care or residential care is not covered.

Outpatient Benefits

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

**Outpatient Facility Fee** incurred for use of such facility.

**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.

**Rehabilitative and Habilitative Therapy** when prescribed by the attending Physician, limited to one visit per day.

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

**In Office Physician’s Visits** 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.

**Private Duty Nursing** in Insured Person’s home when prescribed by a Physician as Medically Necessary to treat a Covered Injury or Covered Sickness.

**Urgent Care Centers of Facilities** for services provided at an Urgent Care Center or Facility, as shown in the Schedule of Benefits. We will not pay for more than one visit per day.

**Diagnostic X-ray Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.

**Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

**Prescription Drugs** 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.

1. **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 the 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, HIV, ARC or AIDS; 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. 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 of this benefit.

2. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

3. **Specialty Drugs** – are Prescription Drugs which: a. Are only approved to treat limited patient populations, indications, or conditions; or b. Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or c. 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.

**Outpatient Miscellaneous Expenses (Excluding surgery)** 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.

**Home Health Care Expense** for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a Skilled Nursing Facility would have been necessary.

**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.

**Dialysis Treatment** in an outpatient facility, or home dialysis and training for the Insured Person and the person who will help the Insured Person with the home self-dialysis.

**Other Benefits**

**Ambulance Service** for transportation to or from a Hospital by ambulance.

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

**Maternity Benefit** for maternity charges as follows: 1. Routine prenatal care. 2. Hospital stays for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. 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 provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item “2”, 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** when expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to: 1. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother; 2. Inpatient Physician visits for routine examinations and evaluations; 3. Charges made by a Physician in connection with a circumcision; 4. Routine laboratory tests; 5. Postpartum home visits prescribed for a newborn; 6. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and 7. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the Treatment of such newly born child. The benefit payable for transportation will not exceed the Usual and Reasonable charges.

**Consultant Physician Services** when requested and approved by the attending Physician.

**Accidental Injury Dental Treatment** as the result of Injury. Treatment must begin within 12 months of the Injury. Routine dental care and Treatment are not payable under this benefit.

**Medical Evacuation and Repatriation** to be eligible for this benefit, an Insured Student must: a) be an International Student enrolled in the authorized college or school during the period for which coverage is purchased. or b) be a Eligible Domestic Student participating in a study abroad program sponsored by the College or School. An eligible International Student must meet the definition of same. An International Student may also enroll his or her Dependent under this Section by payment of additional premium. As used in this Section, an Eligible Domestic Student means a permanent resident of the United States who is enrolled at the college or school and who is temporarily participating in international educational activities outside their Home Country.

The maximum combined benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits.

**Medical Evacuation Expense** — If: 1. An Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness; 2. That occurs while he or she is covered under this Certificate, 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.

**Pediatric Dental Care** for the following dental care services for Insured Persons up to age 19.

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

b. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
   1. Prophylaxis (scaling and polishing the teeth at six (6) month intervals;)
   2. Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
   3. Sealants on unrestored permanent molar teeth; and
   4. Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

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

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

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

Fixed bridges are not Covered unless they are required:
   1. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
   2. For cleft palate stabilization; or
   3. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

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

Procedures include but are not limited to:
   1. Rapid Palatal Expansion (RPE);
   2. Placement of component parts (e.g. brackets, bands);
   3. Interceptive orthodontic Treatment;
   4. Comprehensive orthodontic Treatment (during which orthodontic appliances are placed for active Treatment and periodically adjusted);
   5. Removable appliance therapy; and

**Pediatric Vision Care Benefit** for Insured Persons who are age 18 and under. We will provide benefits for: a) One vision examination per Policy Year; and b) One pair of prescription and eyeglass frames every Policy Year.

**Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.

**Hearing Aids** provided to a newborn for initial amplification following coverage for newborn hearing screening, audiological assessment, and any necessary rescreening or follow-up. This benefit does not cover adults or children older than newborns.

**Reconstructive Surgery** benefits to correct significant deformities caused by congenital or developmental abnormalities, illness, injury or an earlier Treatment in order to create a more normal appearance.
Mandated Benefits for Missouri

Benefits are subject to the conditions and limitations of the policy and as shown in the Schedule of Benefits.

**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.

**Clinical Trials Benefit:** We will pay the expenses incurred for Routine Insured Person Care Costs as the result of phase II, III, or IV of a clinical trial that is approved by an entity listed below and is undertaken for the purposes of the prevention, early detection, or Treatment of cancer. Coverage includes Routine Insured Person Care Costs incurred for drugs and devices that have been approved for sale by the Food and Drug Administration (FDA), regardless of whether approved by the FDA for use in treating the Insured Person’s particular condition, including coverage for reasonable and Medically Necessary services needed to administer the drug or use the device under evaluation in the clinical trial.

In the case of Treatment under a clinical trial, the treating facility and personnel must have the expertise and training to provide the Treatment and treat a sufficient volume of patients. There must be equal to or superior, non-investigational Treatment alternatives and the available clinical or preclinical data must provide a reasonable expectation that the Treatment will be superior to the non-investigational alternatives.

Coverage for Routine Insured Person Care Costs for phase III or IV of clinical trials must be approved or funded by one of the following entities: 1. One of the National Institutes of Health (NIH); 2. An NIH Cooperative Group; 3. The FDA in the form of an investigational new drug application; 4. The federal Departments of Veterans' Affairs or Defense; 5. An institutional review board in this state that has an appropriate assurance approved by the Department of Health and Human Services assuring compliance with and implementation of regulations for the protection of human subjects (45 CFR 46); or 6. A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Coverage for Routine Insured Person Care Costs for phase II is provided if: 1. Phase II of a clinical trial is sanctioned by the National Institutes of Health (NIH) or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center; and 2. The Insured Person is enrolled in the clinical trial. Benefits are not payable for persons who are only following the protocol of phase II of a clinical trial, but not actually enrolled.

As used in this benefit:

**Cooperative Group** means a formal network of facilities that collaborate on research projects and have an established NIH-approved Peer Review Program operating within the group, including the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program.

**Routine Insured Person Care Costs** means reasonable and Medically Necessary services needed to administer the drug or device under evaluation in the clinical trial. Routine Insured Person Care Costs include all items and services that are otherwise generally available to an Insured Person that are provided in the clinical trial except: 1. The investigational item or service itself; 2. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Insured Person; and 3. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

**Early Intervention Services Benefit:** We will pay the expenses incurred for Early Intervention Services described that are delivered by early intervention specialists who are health care professionals licensed by the state of Missouri and acting within the scope of their professions for children who are Insured Persons from birth to age three (3) identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Such coverage shall be limited to $3,000 for each Insured Person per Policy Year, with a maximum of $9,000 per Insured Person.

As used in this benefit:

**Early Intervention Services** means Medically Necessary speech and language therapy, occupational therapy, physical therapy, and assistive technology devices for children from birth to age three (3) who are identified by the Part C early intervention system as eligible for services under Part C of the Individuals with Disabilities Education Act, 20 U.S.C. Section 1431, et seq. Early Intervention Services shall include services under an active individualized family service plan that enhance functional ability without effecting a cure. An individualized family service plan is a written plan for providing Early Intervention Services to an eligible child and the child’s family that is adopted in accordance with 20 U.S.C. Section 1436. The Part C early intervention system, on behalf of its contracted regional Part C early intervention system centers and providers, shall be considered the rendering provider of services for purposes of this benefit.

Benefits payable under the Preventive Services Benefit will be paid under that benefit and not this benefit.
**Enteral Formula Benefit**: We will pay the expenses incurred for formula and Low Protein Modified Food Products recommended by a Physician for the Treatment of an Insured Person with phenylketonuria or any inherited disease of amino and organic acids and who is less than six (6) years of age. Benefits are subject to the same Deductible as for other Covered Sicknesses and payable at 50% of the cost of the formula and food products to a Maximum Benefit of $5,000 Insured Person per Policy Year.

As used in this benefit:

**Low Protein Modified Food Products** means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a Physician for the dietary Treatment of any inherited metabolic disease. Low Protein Modified Food Products do not include foods that are naturally low in protein.

**Dental Anesthesia Benefit**: We will pay the expenses incurred for administration of general anesthesia and hospital charges for dental care provided to the following Insured Persons: 1. A child under the age of five; 2. A person who is severely disabled; or 3. A person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.

This benefit does not cover the dental procedure.

**Low-Dose Mammography Screening** for any nonsymptomatic woman covered under the Policy. We will cover: 1. A baseline mammogram for women age thirty-five to thirty-nine, inclusive; 2. A mammogram for women age forty to forty-nine, inclusive, every two years or more frequently based on the recommendation of the Insured Person’s Physician; 3. A mammogram every year for women age fifty or over; 4. A mammogram for any woman, upon the recommendation of a Physician, where such woman, her mother or her sister has a prior history of breast cancer.

As used in this benefit:

**Low-Dose Mammography Screening** means the X-ray examination of the breast using equipment specifically designed and dedicated for mammography, including the X-ray tube, filter, compression device, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast, and any fee charged by a radiologist or other Physician for reading, interpreting or diagnosing based on such X-ray.

**Treatment of Breast Cancer Benefit**: We will pay the expenses incurred for the Treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer Treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants. We will pay the benefit shown in the Schedule of Benefits.

**Reconstructive Surgery Following Mastectomy Benefit**: We will pay the expenses incurred for the surgical procedure known as a Mastectomy. We will also provide coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as recommended by the oncologist or primary care Physician for the Insured Person incident to the Mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the same Deductible and Coinsurance conditions as for other Covered Sicknesses.

As used in this benefit:

**Mastectomy** means the removal of all or part of the breast for Medically Necessary reasons, as determined by a Physician.

**Autism Treatment Benefit**: We will pay the expenses incurred for the diagnosis, Applied Behavior Analysis, and Treatment of Autism Spectrum Disorders for Insured Persons through eighteen (18) years of age. Benefits are limited to Medically Necessary Treatment that is ordered by the Insured Person’s Physician in accordance with a Treatment Plan. Benefits payable to an Autism Service Provider or a board certified behavior analyst shall include payments or reimbursements for services provided by a Line Therapist under the supervision of such provider or behavior analyst if such services provided by the Line Therapist are included in the Treatment Plan and are deemed Medically Necessary.

We have the right, at Our expense, to review the Insured Persons’ Treatment Plan every six months unless We and the Insured Person’s Physician agree that a more frequent review is necessary.

The Maximum Benefit payable is $40,000 per Policy Year per Insured Person. As used in this benefit:

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

**Autism Spectrum Disorders** means a neurobiological disorder, an illness of the nervous system, which includes Autistic Disorder, Asperger’s Disorder, Pervasive Developmental Disorder Not Otherwise Specified, Rett’s Disorder, and Childhood Disintegrative Disorder, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.
Autism Service Provider means: 1. Any person, entity, or group that provides diagnostic or Treatment services for Autism Spectrum Disorders who is licensed or certified by the state of Missouri; or 2. Any person who is licensed under chapter 337 as a board certified behavior analyst by the behavior analyst certification board or licensed under chapter 337 as an assistant board certified behavior analyst.

Habilitative or Rehabilitative Care means professional, counseling, and guidance services and Treatment programs, including applied behavior analysis, that are necessary to develop the functioning of an individual.

Line Therapist means an individual who provides supervision of an individual diagnosed with an autism diagnosis and other neuro-developmental disorders pursuant to the prescribed Treatment plan, and implements specific behavioral interventions as outlined in the behavior plan under the direct supervision of a licensed behavior analyst.

Pharmacy Care means medications used to address symptoms of an Autism Spectrum Disorder prescribed by a Physician, and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications only to the extent that such medications are included in the Insured Person’s health benefit plan.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

Therapeutic Care means services provided by licensed speech therapists, occupational therapists, or physical therapists.

Treatment Plan means care prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder by a Physician including equipment Medically Necessary for such care, pursuant to the powers granted under such licensed Physician’s or licensed psychologist’s license, including, but not limited to: 1. Psychiatric Care; 2. Psychological Care; 3. Habilitative or Rehabilitative Care, including applied behavior analysis therapy; 4. Therapeutic Care; and 5. Pharmacy Care.

Second Opinion for Cancer Benefit: We will pay the expenses incurred for a second opinion rendered by a specialist in that specific cancer diagnosis area when an Insured Person with a newly diagnosed cancer is referred to such specialist by his or her attending Physician.

Leukocyte Antigen Testing Benefit: We will pay the expenses incurred for up to $75 for human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B, and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility which is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. Section 263a, as amended, and is accredited by the American Association of Blood Banks or its successors, the College of American Pathologists, the American Society for Histocompatibility and Immunogenetics (ASHI) or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists. At the time of testing, the Insured Person being tested must complete and sign an informed consent form which also authorizes the results of the test to be used for participation in the National Marrow Donor Program.

Oral Chemotherapy Benefit: We will pay the expenses incurred for prescribed orally administered anticancer medications on the same basis as intravenously administered or injected anticancer medications.

Diabetes: We will pay the expenses incurred for all Physician prescribed Medically Necessary equipment, supplies and self-management training used in the management and Treatment of diabetes. Coverage shall include Insured Persons with gestational, type I or type II diabetes.

Telehealth Services: We will pay the expenses incurred for Telehealth on the same basis as if the service would be covered through face-to-face diagnosis, consultation or Treatment.

As used in this benefit:

Telehealth means the use of medical information exchanged from one site to another via electronic communications to improve the health status of an Insured Person.

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 - Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.

2. Preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy under the
Preventive Services Benefit.

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 under the Preventive Services Benefit.

4. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.

5. dental Treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to Sound, Natural Teeth or in the Pediatric Dental Benefit.

6. professional services rendered by an Immediate Family Member or any who lives with the Insured Person.

7. 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 as specifically covered under the Policy.

8. weak, strained or flat feet, corns, calluses or ingrown toenails.

9. diagnostic or surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.

10. 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.

11. expenses covered under any Workers’ Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.

12. charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.

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 Schedule of Benefits.

16. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;

17. intentionally self-inflicted Injury, attempted suicide, or suicide, while sane.

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. expenses incurred during a Hospital emergency room visit which is not of an emergency nature.

20. 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.

21. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.

22. charges incurred for acupuncture, heat Treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.

23. expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.

24. 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.

a. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical Treatment within 24 hours of the Accident or results from Reconstructive Surgery. For the purposes of this provision, Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.

b. For the purposes of this provision, Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient’s appearance.

25. Treatment to the teeth, including surgical extractions of teeth and any Treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Policy definition of the same. This exclusion does not apply to the repair of Injuries caused by a Covered Injury.
to the limits shown in the Schedule of Benefits.

26. an Insured Person’s:
   o committing or attempting to commit a felony,
   o being engaged in an illegal occupation, or
   o participation in a riot.

27. elective abortions.

28. braces and appliances, except as specifically provided in the Schedule of Benefits.

29. congenital defects, except as provided for newborn or adopted children added after the Effective Date of coverage.

30. custodial care service and supplies.

31. act of terrorism.

32. conditions due to accidental bodily injury occurring prior to the Insured Person’s effective date of coverage.

33. Physician’s charges for diagnosis and Treatment of structural imbalance, distorting or subluxation in vertebral column or elsewhere in body by manual, mechanical means, through muscular-skeletal adjustments, manipulations, and related modalities except as specifically covered under the Chiropractic Care Benefit.

Section 5 – CLAIM PROCEDURE
In the event of Accident or Sickness the student should:
1. If at the College, report immediately to Your Physician so that proper Treatment can be prescribed or approved. Notify Us within 90 days after the date of the Covered Injury or commencement of the Covered Sickness. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

2. If away from the College, consult a doctor and follow his or her advice. Notify Us within 90 days after the date of the Covered Injury or commencement of the Covered Sickness. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible.

3. If a claim form is not furnished to You within 15 days after We receive notice of the claim, the Insured Person making such claim shall be deemed to have complied with the proof of loss requirement by giving Us a written statement of the nature and extent of the loss within 90 days.

4. Complete the form.

5. Submit the claim form, complete with bills and receipts, to the Claims Administrator: Consolidated Health Plans 2077 Roosevelt Avenue, Springfield, MA 01104. Written proof of loss must be furnished to Us or to Our authorized agent within 90 days after the date of such loss. If it was not reasonably possible to give written proof in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. The proof required must be given no later than one year from the time specified unless You were legally incapacitated.

6. Submit only one claim form for each Accident or Sickness.

Section 6 – Coordination of Benefits
If the Insured Person is insured under more than one group health plan, the benefits of the plan that covers the Insured Student will be used before those of a plan that provides coverage as a Dependent Insured Person. When both parents have group health plans that provide coverage as a Dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy on file with the Policyholder.

Section 7 - Appeals Procedure
For purposes of this Section, the following definitions apply:
Adverse Determination means a determination by Us or Our designee utilization review organization 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.

**Prospective Review** means utilization review conducted prior to an admission or course of Treatment.

**Retrospective Review** means a review of medical necessity conducted after services have been provided to an Insured Person but does not include the review of the claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

**Internal Review Procedure**

In the event of an Adverse Determination, We will notify the Insured Person immediately in writing of Our decision and the reason for the Adverse Determination. The notice will include a description of any additional information that might be necessary for reconsideration of the claim and the notice will also describe the right to appeal. The Insured Person also has the right to contact the Commissioner of Insurance or his or her office at any time.

A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. The Insured Person does not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative may:

1. Review all documents related to the claim and submit written comments and issues related to the denial; and
2. Submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

We will provide the Insured Person with the contact person who is coordinating the first level review within 3 days of the date of receipt of the grievance.

After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 20 working days for a Prospective Review request or 50 working days for a Retrospective Review request after receipt of the notice requesting the first level review. If the review cannot be completed within 20 working days after receipt of the grievance, the Insured Person shall be notified in writing on or before the 20th working day and the review shall be completed within 30 working days thereafter. The notice shall set forth with specificity the reasons for which additional time is needed for the investigation.

We shall provide free of charge to the Insured Person, or the Insured Person’s authorized representative, any new or additional evidence, relied upon or generated by Us, or at Our direction, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the Insured Person, or the Insured Person’s authorized representative, a reasonable opportunity to respond prior to the date.

Before We issue or provide notice of a final Adverse Determination that is based on new or additional rationale, We shall provide the new or additional rationale to the Insured Person, or the Insured Person’s authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final Adverse Determination is to be provided to permit the Insured Person, or the Insured Person’s authorized representative a reasonable opportunity to respond prior to the date.

In the case of an Adverse Determination involving utilization review, We will designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to determine Adverse Determination. The clinical peer(s) shall not have been involved in the initial adverse determination. We shall ensure that the individuals reviewing the Adverse Determination have appropriate expertise. Within 5 working days after the review is completed, the clinical peer(s) shall notify the Insured Person in writing of the decision regarding the grievance and of the right to file an appeal for a second level review. The notice shall explain the resolution of the grievance and the right to appeal in terms which are clear and specific. Within 15 working days after the review is completed, We will notify the person who submitted the grievance of the decision of said grievance.

**Expedited reviews of grievances involving an Adverse Determination**

We shall provide expedited review of a grievance involving an Adverse Determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility. The Insured Person or the Insured Person’s authorized representative shall request an expedited review orally or in writing. We will appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the Adverse Determination. The clinical peer or peers shall not have been involved in making the initial Adverse Determination. In an expedited review, all necessary information, including the health carrier’s decision, shall be transmitted between the Insured Person or, if applicable, the Insured Person’s authorized representative and Us by telephone, facsimile or the most expeditious method available. An expedited review decision shall be made and the Insured Person or, if applicable, the Insured Person’s authorized representative shall be notified of the decision within seventy two (72) hours after the receipt of the request for the expedited review.
If the expedited review is of a grievance involving an Adverse Determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the Insured Person until the Insured Person has been notified of the determination.

If the Insured Person Disagrees with Our Internal Review Determination
In the event that the Insured Person disagrees with Our internal review determination, the Insured Person or his or her authorized representative may:

1. File a complaint with the Department of Insurance, P.O. Box 690, Jefferson City, MO 65102-0690; (800) 726-7390 and www.insurance.mo.gov/consumers/complaints or

2. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

The Insured Person may contact the Missouri Department of Insurance for assistance at any time.
Address: 301 W. High Street, Room 530
P.O. Box 690
Jefferson City, MO 65102-0690
Phone:  (800) 726-7390 or (573) 751-4126

The Insured Person also has the right to bring a civil action in a court of competent jurisdiction. Note that he or she may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the state Insurance Commissioner.

External Review Procedure
1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 20 working days. If an Insured Person has an Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

   We shall notify the Insured Person in writing of the Insured Person’s right to request an external review at the time the We send written notice of: a. An Adverse Determination upon completion of Our utilization review process described above; or b. A final Adverse Determination.

   An external review may be requested within 60 days after the Insured Person receives Our adverse benefit determination. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.

2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person.

3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.

4. We will review the request and if it is:
   a. Complete We will initiate the external review and notify the Insured Person of: i. The name an contact information for the assigned independent review organization or the Commissioner of Insurance, as applicable for the purpose of submitting additional information; and ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn’t apply to expedited request or external reviews that involve an experimental or investigational Treatment.
   b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.

5. We will not afford the Insured Person an external review if:
   a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   The Insured Person has failed to exhaust Our internal review process; or The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us. If We deny a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, We will notify the Insured Person in writing: a. The reason for the denial; and b. That the denial may be appealed to the Commissioner of Insurance.

6. For an expedited review: the Insured Person may make a request for an expedited external review after receiving an adverse benefit determination if:
   a. The Insured’s treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time
frame of an expedited internal review.

b. The Insured Person’s treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person, or would jeopardize the Insured Person’s ability to regain maximum function, if treated after the time frame of a standard external review. Or
c. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.

7. An Insured Person shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by Us, the insurer.

8. At the request of the independent review organization, the Insured Person, provider, health care facility rendering health care services to the Insured Person, or Us shall provide any additional information the independent review organization requests to complete the review.

9. If the independent review organization does not receive any requested information necessary to complete the review they are not required to make a decision. They shall notify the Insured Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means.

10. We may elect to cover the service requested and terminate the review. We shall notify the Insured Person and all other parties involved with the decision by mail, or with the consent or approval of the Insured Person, by electronic means.

11. In the case of an expedited review, the independent review organization shall issue a written decision within seventy-two (72) hours after being assigned an expedited external review. In all other cases, written decision shall be issued no later than thirty (30) days after the filing of the request for review to the Insured Person, the insurer and the Insured Person’s provider or the health care facility if they requested the review. The written decision shall include a description of the Insured Person’s condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

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

External Review of Denial of Experimental or Investigative Treatment

Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination that involves a denial of coverage based on a determination that the health care service or Treatment recommended or requested is experimental or investigational, an Insured Person or the Insured Person’s authorized representative may file a request for external review with the Commissioner of Insurance.

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

Upon receipt of a request for an expedited external review, the Commissioner of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Commissioner of Insurance immediately shall notify and send a copy of the request to Us. For an expedited external review request, at the time We receive the notice, We or Our designee utilization review organization shall provide or transmit all necessary documents and information considered in making the Adverse Determination or final Adverse Determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.
Service Representative:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5030
www.chompstudent.com

Underwritten by:
National Guardian Life Insurance Company
as policy form # NBH-280 PPO (2016) MO et al

Administered by:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5030
www.chompstudent.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:
National Guardian Life Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502

(Please indicate the school you attend with your written request.)

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

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.
VALUE ADDED SERVICES
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.chpstudent.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-877-657-5030. 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.

Your out-of-pocket costs may be lower when you utilize Cigna PPO Providers. For a listing of Cigna PPO Providers, go to www.cigna.com or contact Consolidated Health Plans toll-free at (877) 657-5030, or www.chpstudent.com for assistance.