Student Health Insurance Plan

Plan Year 17/18

Designed Exclusively for the Students of:
Ottawa University
Ottawa, KS
2017 - 2018

Underwritten by:
National Guardian Life Insurance Company
Madison, WI

Policy Number: 2017I5C09
Group Number: ST1083SH
Effective: 8/9/2017 - 8/9/2018

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?**
If You are eligible to be covered under this Program, You are automatically enrolled, unless You waive coverage. If you have other insurance, you may waive coverage by completing the University’s Health Insurance Waiver Form by the deadline date below.

**EFFECTIVE DATES AND COSTS**

<table>
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<tr>
<th>Coverage Period</th>
<th>Coverage Start Date</th>
<th>Coverage End Date</th>
<th>Enrollment/Waiver Deadline</th>
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</thead>
<tbody>
<tr>
<td>Fall</td>
<td>08/09/2017</td>
<td>02/10/2018</td>
<td>09/01/2017</td>
</tr>
<tr>
<td>Spring/Summer</td>
<td>02/10/2018</td>
<td>08/09/2018</td>
<td>02/01/2018</td>
</tr>
</tbody>
</table>

**Rates for Domestic and International Students**

<table>
<thead>
<tr>
<th></th>
<th>Fall</th>
<th>Spring/Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$826</td>
<td>$826</td>
</tr>
</tbody>
</table>

*The above rates include an administrative service fee*
Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent or the Administrative Agency CHP.

**Coverage**

1. Accident and Sickness coverage begins on August 9, 2017, or the date of enrollment in the plan, whichever is later and ends August 9, 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.
3. The Policy provides benefits based on the type of health care provider the insured Student and his or her Covered Dependent selects. The Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

**Certificate of Student Group Health Insurance**

Issued by

NATIONAL GUARDIAN LIFE INSURANCE COMPANY, PO BOX 1191, Madison, WI 53701-1191

(Herein referred to as ‘We’, ‘Us’ or ‘Our’)

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2016) KS (“the Policy”).

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**Section 1 — Definitions**

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

**Accident** means a sudden, unforeseeable external event that causes injury to an Insured Person. The Accident must occur while coverage is in effect for the 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, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

**Copayment** means the amount of Usual and Reasonable expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.
**Country of Assignment** means the country in which an Eligible International Student, scholar or visiting faculty member is:
1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

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

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

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

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

Covered Sickness includes Mental Health Disorders and Substance Abuse 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.

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

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

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

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

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

**Essential Health Benefits** mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

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

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

Habilitation/Habilitative Services means health care services that help the Insured Person keep, learn, or improve skills and functions of daily living. Habilitative Services may include such services as physical therapy, occupational therapy, and speech therapy.

Home Country means the Insured Student’s country of citizenship. If the Insured Student has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the United States. The Insured Student’s Home Country is considered the Home Country for any dependent of an Insured Student while insured under the Policy.

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

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

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

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.

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

Insured Person means an Insured Student or dependent of an Insured Student 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.

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

Medically Necessary means 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 means Physicians, Hospitals, and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

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

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a “Physician.” This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, 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.

Preferred 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 the Insured Student.

Skilled Nursing Facility – 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.

Specialty Drugs means drugs that are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the Insured Person’s drug therapy.

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.

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

Usual and Reasonable (U & R) means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the same geographic locality or area for a:
1. Like or comparable service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.
The Usual and Reasonable charge shall come from the Fair Health database of charges. 

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

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

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

**Section 2 – Eligibility, Enrollment and Termination**

All undergraduate students taking 9 or more credit hours and graduate students enrolled in 6 or more credit hours are eligible to enroll in this plan. Students will be required to show proof of adequate insurance or be automatically enrolled in the insurance plan. When automatically enrolled, students will be assessed the fees for the plan. 

Any Insured voluntarily withdrawing from school during the first thirty-one (31) days of the period for which Coverage is purchased, will not be covered under the Policy and a full refund of Premium will be made. Insured withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed except as otherwise specified. 

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

**Extension of Benefits:** Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended as follows: 1) If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for 90 days from the Termination Date while such confinement continues. 

**Section 3 — BENEFITS**

Benefits are payable under the policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Insured Person. 

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

**Preventive Services:** The following services shall be covered without regard to any Deductible, or Coinsurance requirement that would otherwise apply: 1) Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; 2) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved; 3) With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 4) With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph 1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. 

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

**Treatment of Covered Injury or Covered Sickness:** We will pay benefits for the Usual and Reasonable Charges for Covered Medical Expenses that are incurred by the Insured Person due to a Covered Injury or Covered Sickness. Benefits payable are subject to: 1) 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) the Exclusions and Limitations provision. 

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

**Preferred Provider Organization (PPO)**

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.

### SCHEDULE OF BENEFITS

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<thead>
<tr>
<th>Benefit Period</th>
<th>8/9/2017 - 8/9/2018</th>
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<tbody>
<tr>
<td></td>
<td>NETWORK</td>
</tr>
<tr>
<td>Preventive Services</td>
<td>The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Actual Charge/Usual and Reasonable Charge when services are provided through a Network Provider.</td>
</tr>
<tr>
<td>See the attached Administrative Change Endorsement</td>
<td></td>
</tr>
<tr>
<td>Deductible</td>
<td>$300</td>
</tr>
<tr>
<td>Out-of-Pocket Expense Limit</td>
<td>Individual $3,750</td>
</tr>
<tr>
<td>Coinsurance Amount</td>
<td>80% of PPO Allowance for Covered Medical Expenses unless otherwise stated below</td>
</tr>
<tr>
<td>Hospital Inpatient Facility Copayment</td>
<td>$500</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>NETWORK</td>
</tr>
<tr>
<td>Inpatient Benefits</td>
<td></td>
</tr>
<tr>
<td>Hospital Room &amp; Board Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room &amp; Board Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>NETWORK</td>
</tr>
<tr>
<td>-------------------------------------</td>
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</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>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Physician’s Visits while Confined</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Inpatient Surgery:</td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>25% of benefits payable for Surgeon Services</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>25% of benefits payable for Surgeon Services</td>
</tr>
<tr>
<td>Registered Nurse Services for private duty nursing while confined</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Physical Therapy (inpatient)</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Skilled Nursing Facility Expense Benefit</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td><strong>Outpatient Benefits</strong></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery:</td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>25% of benefits payable for Surgeon Services</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>25% of benefits payable for Surgeon Services</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>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Rehabilitation Therapy Benefit</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Emergency Services Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Copayment: $200</td>
<td>Copayment: $200</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>NETWORK</td>
</tr>
<tr>
<td>-------------------------------------</td>
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</tr>
<tr>
<td>Urgent Care</td>
<td>80% of PPO Allowance for Covered Medical Expenses Copayment: $75</td>
</tr>
<tr>
<td>In Office Physician’s Visits</td>
<td>80% of PPO Allowance for Covered Medical Expenses Copayment: $40</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Diagnostic X-ray Services</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Laboratory Procedures (Outpatient)</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Shots and Injections unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Infusion Therapy</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>80% of PPO Allowance for Covered Medical Expenses Copayment: $25 Generic Copayment: $50 Preferred Brand Copayment: $50 Brand Copayment: $50 Specialty Drug Paid on a reimbursement basis</td>
</tr>
<tr>
<td>Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery.</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Home Health Care Expenses up to 5 visits per Policy Year</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hospice Care Coverage</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
</tr>
</tbody>
</table>

**Other Benefits**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Service</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Braces and Appliances, including Prosthesis and Orthotics</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>-------------------------------------</td>
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</tr>
<tr>
<td>Maternity Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</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</td>
<td>100%, limited to 2 dental exams every 12 months</td>
<td>70%, limited to 2 dental exams every 12 months</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Routine Dental Care, Diagnostic Services and Treatment Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Oral Surgery</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>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</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Spinal Manipulation Services</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Mental Illness, Alcoholism, Drug Abuse or Substance Use</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunction Syndrome Benefit</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Infertility Treatment Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Consultant Physician Services – when requested by the attending physician</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment for Insured Persons over age 18</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate, intramural or club sports</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Non-Emergency Medical Treatment Received When Traveling Outside the United States</td>
<td>60% PPO Allowance for Covered Medical Expenses</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
</tbody>
</table>

**Mandated Benefits**

<p>| Cancer Clinical Trial Benefit        | Same as any other Covered Sickness | Same as any other Covered Sickness |
| Dental Anesthesia Benefit            | Same as any other Covered Sickness | Same as any other Covered Sickness |</p>
<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Care Management Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Mammograms and Pap Smears Benefit</td>
<td>Same as any other Preventive Service</td>
<td>Same as any other Preventive Service</td>
</tr>
<tr>
<td>Osteoporosis Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Prostate Cancer Screening Benefit</td>
<td>Same as any other Preventive Service</td>
<td>Same as any other Preventive Service</td>
</tr>
</tbody>
</table>

**Inpatient Benefits**

1. **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.

2. **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.

3. **Hospital Miscellaneous Expenses**, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
   - a. The cost for use of an operating room;
   - b. Prescribed medicines;
   - c. Laboratory tests;
   - d. Therapeutic services;
   - e. X-ray examinations;
   - f. Casts and temporary surgical appliances;
   - g. Oxygen, oxygen tent;
   - h. Blood and blood plasma; and
   - i. Miscellaneous supplies.

4. **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.

5. **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.

6. **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.

   Benefits also include the following Medically Necessary Human Organ and Tissue Transplant surgery to the extent that the surgery is not Experimental or Investigational Treatment: autologous and nonautologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, small intestine, multivisceral transplants, and pancreas/kidney transplants. We will also pay the cost associated with the donor search and acquisition of bone marrow or peripheral stem cells when a related donor is not available for up to $35,000 per transplant.

7. Benefits also include coverage for a mastectomy and breast reconstruction in connection with such mastectomy including coverage for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending Physician and the Insured Person.
8. **Registered Nurse’s Services**, when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.

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

10. **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

1. **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.

2. **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:
   a. Operating room;
   b. Therapeutic services;
   c. Oxygen, oxygen tent;
   d. Blood and blood plasma; and
   e. Miscellaneous supplies.

3. **Rehabilitation Therapy Benefit** for outpatient rehabilitation services including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy, and speech therapy due to a Covered Injury or Covered Sickness.

4. **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.

5. **Urgent Care** for services provided at an Urgent Care Center or Facility, as shown in the Schedule of Benefits. Urgent Care is medical care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care. If Urgent Care results in an emergency room admission, please follow the instructions for Emergency Services described above.

6. **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. Visits to other qualified practitioners including registered graduate nurses and physicians assistants are covered. Surgeon fees are NOT payable under this benefit.

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

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

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

10. **Shots and Injections** administered in an emergency room or Physician’s office and charged on the emergency room or Physician’s statement.

11. **Infusion Therapy** - Covered Expense for Infusion Therapy (including all professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment and training related to Infusion Therapy) will not exceed the Average Wholesale Price as determined by the Insurer or the Negotiated Rate: Covered Services for Infusion Therapy are as follows:
   a. Professional services to order, prepare, compound, dispense, deliver, administer, train or monitor (including clinical pharmacy support) any drugs or other substances used in Infusion Therapy.
   b. All necessary supplies and durable medical equipment including, but not limited to, bandages, cotton swabs, intravenous starter kits, tubing, syringes, needles, pump, pole, and electronic monitor.
   c. The Infusion Therapy Drugs or other substances.
   d. Blood transfusions, including blood processing and the cost of unreplaced blood and blood products.

12. **Prescription Drugs** -
   a. We will pay the expenses incurred for medication for which a Physician’s written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the
treatment of the Covered Injury or Covered Sickness for which a claim is made. Also covered are prescribed contraceptives and orally administered anti-cancer medicine used to kill or slow the growth of cancerous cells.
b. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
   i. The drug is approved by the FDA;
   ii. The drug is prescribed for the treatment of a life-threatening condition including cancer and treatment of human immunodeficiency virus or acquired immunodeficiency syndrome;
   iii. The drug has been recognized for treatment of that condition by one of the following:
      i. The American Medical Association Drug Evaluations;
      ii. The American Hospital Formulary Service Drug Information.
      iii. The United State Pharmacopoeia Dispensing Information, volume 1, “Drug Information for Health Care Professionals”;
      or
   iv. 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.
   However, if the prescribed drug is being used for cancer treatment, coverage for the drug shall not be excluded because the drug has not been approved by the FDA for that covered indication, if the drug is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer review medical literature.
   When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items i., ii., and iii. of this benefit.
   As it pertains to this benefit, life threatening means either or both of the following:
   i. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted;
   or
   ii. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.
13. Outpatient Miscellaneous Expenses (Excluding surgery) for miscellaneous outpatient expenses (excluding surgery) incurred for the treatment and care of a Covered Injury or Covered Sickness, including the outpatient facility fee. 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.
14. 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. Benefits include private duty nursing in addition to care by a home health aide according to a treatment plan prescribed by a qualified Physician. Home Health Care visits related to maternity care will be payable under the Maternity Benefit and not this Benefit.
15. 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 Care rather than curative care.
   As used in this benefit:
   Hospice Care means a coordinated program of home and inpatient care provided directly or under the direction of a properly licensed Hospice. Such services will include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medical directed interdisciplinary team.

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.

Other Benefits
1. Ambulance Service for transportation to or from a Hospital by ground and air ambulance. Transportation is limited to within a 500 mile radius of the Hospital.
2. Braces and Appliances, including Prosthesis and Orthotics when prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We also cover the Usual and Reasonable expense incurred for two mastectomy
3. bras per Policy Year. We will also not pay for prosthetics or orthotics when used as protective devices during a student’s participation in sports. Replacement prosthetics and orthotics are not covered.

4. **Durable Medical Equipment** 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:
   a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
   b. Be able to withstand repeated use; and
   c. Generally not be useful to a person in the absence of Injury or Sickness.

5. **Chemotherapy and Radiation Therapy** for chemotherapy and radiation therapy, as shown in the Schedule of Benefits. We will also cover orally administered anticancer medications on the same basis.

6. **Maternity Benefit** for prenatal care and maternity charges as follows:
   a. 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.
   b. Inpatient Physician charges or surgeon charges will be covered the same as for any other Covered Sickness for both mother and newborn child.

1. Physician-directed Follow-up Care including:
   - Physician assessment of the mother and newborn;
   - Parent education;
   - Assistance and training in breast or bottle feeding;
   - Assessment of the home support system;
   - Performance of any prescribed clinical tests; and
   - Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

   This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item “a”, the home health care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn.

   c. Outpatient Physician’s visits will be covered the same as for any other Covered Sickness.

7. **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:
   a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   b. Inpatient Physician visits for routine examinations and evaluations;
   c. Routine and necessary immunizations;
   d. Charges made by a Physician in connection with a circumcision;
   e. Routine laboratory tests;
   f. Postpartum home visits prescribed for a newborn;
   g. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and
   h. 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 up to $200.00.

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

   Emergency dental care, which includes emergency room services provided by a dentist and inpatient Hospital services and treatment required to alleviate pain and suffering caused by dental disease or trauma.

   Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
   a. Cleaning and prophylaxis (scaling and polishing the teeth at six (6) month intervals;
b. Fluoride treatments (including fluoride varnishes) three (3) times per year;
c. Sealants on unrestored permanent molar teeth; and
d. Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

Routine Dental Care, Diagnostic Services and Treatment Services: We Cover routine dental care, diagnostic and treatment services provided in the office of a dentist, including:

a. Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
b. 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);
c. Root Canals on baby teeth (pulpotomies) or permanent teeth;
d. Gum (periodontal) therapy;
e. In-office conscious sedation;
f. Amalgam, tooth colored composite restorations and stainless steel, metal, or porcelain crowns; and
g. Other restorative materials appropriate for children.

Oral Surgery: We will cover the following:

a. Simple extractions, surgical extractions, care of abscesses, and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
b. Cleft palate treatment;
c. Cancer treatment;
d. Treatment of fractures;
e. Biopsies; and
f. General anesthesia, intravenous conscious sedation (for extensive or complex oral surgical procedures) or analgesia (nitrous oxide).

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

Prosthodontic services as follows:

a. Removable complete or partial dentures, including six (6) months follow-up care; and
b. 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:

a. 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
b. For cleft palate stabilization; or

Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

Orthodontics, including retainers and braces, 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

9. Pediatric Vision Care for emergency, preventive and routine vision care for Insured Persons up to age 19.

Eye Examinations, are covered as needed, when provided by an ophthalmologists and optometrists.

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

a. Case history;
b. External examination of the eye or internal examination of the eye;
c. Ophthalmoscopic exam;
d. Determination of refractive status;
e. Binocular distance;
f. Tonometry tests for glaucoma;
g. Gross visual fields and color vision testing; and
h. Summary findings and recommendation for corrective lenses.

We will cover up to three (3) sets of prescription lenses and up to three (3) pairs of frames in a twelve (12) month period. Standard frames include a one-year warranty, and if non-standard frames are used, the Insured Person will be responsible for the entire expense of the frames. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new frames more frequently, as evidenced by appropriate documentation.

We will also cover contact lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new contact lenses more frequently, as evidenced by appropriate documentation.

10. **Spinal Manipulation Services** manual spinal manipulation Medically Necessary due to a Covered Sickness or Covered Injury.

11. **Temporomandibular Joint Dysfunction Syndrome Benefit** for Medically Necessary surgical and non-surgical treatment of temporomandibular joint dysfunction syndrome.

12. **Infertility Treatment Benefit** for Medically Necessary diagnosis and treatment of infertility. Treatment includes in vitro fertilization or any other medically aided insemination procedure.

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

14. **Accidental Injury Dental Treatment for Insured Person over age 18** as the result of Injury. Routine dental care and treatment are not payable under this benefit.

15. **Sports Accident Expense Benefit** as the result of covered sports accident while at play or practice of intercollegiate, intramural or club sports as shown in the Schedule of Benefits.

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

**Mandated Benefits**

**Cancer Clinical Trial Benefit:**
We will pay the Coinsurance Amount as shown in the Schedule of Benefits for expenses incurred for all routine patient care costs associated with the provision of health care services, including drugs, items, devices, treatments, diagnostics, and services that would otherwise be covered under this plan, if those drugs, items, devices, treatments, diagnostics, and services were not provided in connection with an approved clinical trial program, including health care services typically provided to patients not participating in a clinical trial.

For purposes of this Benefit, “Routine Patient Care Costs” shall not include the costs associated with the provision of any of the following:
1. drugs or devices that have not been approved by the Federal Food and Drug Administration and that are associated with the clinical trial;
2. services other than health care services, including travel, housing, companion expenses, and other nonclinical expenses, that an Insured Person could require as a result of the treatment being provided for purposes of the clinical trial;
3. any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient;
4. health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under the Insured Person’s hospital, medical, or surgical expense policy or certificate; or
5. health care services customarily provided by the research sponsors of a trial free of charge for any Insured Person in the trial.
Dental Anesthesia Benefit: We will pay the Coinsurance Amount as shown in the Schedule of Benefits for the expenses incurred for hospitalization and general anesthesia in order for an Insured Person to safely receive dental care if he or she is:
1. a covered Dependent child five years of age and under; or
2. an Insured Person who is severely disabled; or
3. an Insured Person who has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided.
We do not pay benefits for dentist’s charges unless otherwise covered under the Pediatric Dental Care Benefit.

Diabetes Care Management Benefit: We will pay the Coinsurance Amount as shown in the Schedule of Benefits for the expenses incurred for equipment, and supplies, limited to hypodermic needles and supplies used exclusively with diabetes management and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such services and supplies under the law. Such coverage shall include coverage for insulin only if such coverage also includes coverage of prescription drugs. We will also cover routine foot care for the treatment of diabetes when it is not palliative or cosmetic.
Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. The coverage for outpatient self-management training and education shall be required only if ordered by a health care professional legally authorized to prescribe such services and the diabetic:
1. is treated at a program approved by the American Diabetes Association;
2. is treated by a person certified by the national certification board for diabetes educators; or
3. is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional.

Mammograms and Pap Smears Benefit: We will pay the Coinsurance Amount as shown in the Schedule of Benefits for expenses for mammograms or pap smears when performed at the direction of a person licensed to practice medicine and surgery by the board of healing arts within the lawful scope of such person’s license, including services performed at a mobile facility certified by the Federal Health Care Financing Administration and performing mammography testing by American Cancer Society guidelines.

Osteoporosis Benefit: We will pay the Coinsurance Amount as shown in the Schedule of Benefits for expenses for the diagnosis, treatment and management of osteoporosis for an Insured Person with a condition or medical history for which bone mass measurement is medically necessary, when such services are provided by a person licensed to practice medicine and surgery in the state of Kansas.

Prostate Cancer Screening Benefit: We will pay the Coinsurance Amount as shown in the Schedule of Benefits for expenses for prostate cancer screening for men 40 years or age or older who are symptomatic or in a high-risk category and for all men 50 years or age or older. The screening shall consist, at a minimum, of prostate-specific antigen blood test and a digital rectal examination.

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. dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person’s Sound, Natural Teeth or as specifically covered under the Pediatric Dental Care Benefit.
2. professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
3. services or supplies not necessary for the medical care of the Insured Person’s Injury or Sickness.
4. radial keratotomy and services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury or as specifically covered under the Pediatric Dental Care Benefit.
Vision Care Benefit.

5. expenses covered under any mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.

6. services or Injuries related to the Insured Person’s job to the extent he or she is covered or is required to be covered by the Workers’ Compensation or occupational disease law. If he or she enters into a settlement giving up his or her the right to recover future medical benefits under a Workers’ Compensation or occupational disease law, the policy will not pay those medical benefits that would have been payable in absence of that settlement.

7. 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.

8. any expenses in excess of Usual and Reasonable charges.

9. 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.

10. 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.

11. services that are duplicated when provided by both a certified nurse-midwife and a Physician.

12. expenses payable under any prior Policy which was in force for the person making the claim.

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

14. Injury sustained as the result of the Insured Person’s operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.

15. expenses incurred after:
   o The date insurance terminates as to the Insured Person;
   o The Maximum Benefit for each Covered Injury or Covered Sickness has been attained; and
   o The end of the Benefit Period specified in the Benefit Schedule.

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

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

18. expenses for hearing aids, except as required for repair caused by a Covered Injury or as specifically covered under the Policy.

19. 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.
   o 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.
   o 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).

20. elective abortions.

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

22. custodial care service and supplies.

23. expenses that are not recommended and approved by a Physician.

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

**Section 5 – CLAIM PROCEDURE**

In the event of Accident or Sickness the student should:

1. If at the College, report immediately to Health Services so that proper treatment can be prescribed or approved.

2. If away from the College, consult a doctor and follow his or her advice. Notify Ottawa University within 90 days after the date of the Covered Injury or commencement of the Covered Sickness or as soon thereafter as is reasonably possible.

3. Secure a claim form from the Student Accounts Office, or the Administrator’s website: [www.chpstudent.com](http://www.chpstudent.com)

4. Complete the form.

5. Submit the claim form, complete with bills and receipts, to the Consolidated Health Plans: 2077 Roosevelt Avenue, Springfield, MA 01104

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

Service Representative:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (800) 657-5030
www.chpstudent.com
ST1083SH

Underwritten by:
National Guardian Life Insurance Company
as policy form # NBH-280 (2016) KS

Administered by:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (800) 657-5030
www.chpstudent.com

For a copy of the Company’s privacy notice you may:
go to
www.consolidatedhealthplan.com/about/hipaa
or
Request one from the Health office at your school
Or
Request one from:
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.
Representations of this plan must be approved by Us.

IMPORTANT

THIS CERTIFICATE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE AS DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE AT THE COLLEGE.
It is understood and agreed that the Policy to which this Endorsement is attached is amended as follows:

1. The Policy/Certificate is amended to delete the following provision:

**Preventive Services:**
Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the [actual charge/Usual and Reasonable charge] when services are provided through a Network Provider.

Non-Network: [Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum.] [The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the [actual charge/Usual and Reasonable charge].]

2. The Policy/Certificate is amended to include the following provision:

**Preventive Services:**
Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the PPO Allowance when services are provided through a Network Provider.

Non-Network: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum. The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 70% of the Usual and Reasonable charge.

In every other way, the Policy remains as is.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

President

X ____________________________
Policy Owner’s Signature
(If required by the Company)

____________________________
Countersignature of Licensed
Resident Agent, where required
AMENDMENT TO DEFINITIONS

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

The definition of Accident is deleted in its entirety and replaced with the following:

**Accident** means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

The definition of Covered Injury is deleted in its entirety and replaced with the following:

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

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

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


Kimberly A. Shaul
Secretary

Mark L. Solverud
President
### 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 Plan.

<table>
<thead>
<tr>
<th>VISION DISCOUNT PROGRAM</th>
</tr>
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<tbody>
<tr>
<td>For Vision Discount Benefits please go to:</td>
</tr>
<tr>
<td><a href="http://www.chpstudent.com">www.chpstudent.com</a></td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>EMERGENCY MEDICAL AND TRAVEL ASSISTANCE</th>
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</thead>
<tbody>
<tr>
<td>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. If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 1.877.488.9833 or if you are in a foreign country, call +1.609.452.8570. 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.</td>
</tr>
</tbody>
</table>

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.