Student Health Insurance Plan
designed for
Menlo College
2015–2016

Policy Number: 2015K1A01

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent Gallagher Student Health & Special Risk, 500 Victory Road, Quincy, MA 02171, at 1-844-484-0088.

COVERAGE
1. Accident and Sickness coverage begins on August 1, 2015, or the date of enrollment in the plan, whichever is later and ends August 1, 2016.
2. Benefits are payable during the Policy Term, subject to any Extension of Benefits.
3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.

PREMIUM RATES

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<th>Annual</th>
<th>Fall Only</th>
<th>Spring/Summer</th>
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*Premium rates include the cost of managing the plan.*
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 (2015) CA NPPO ("the Policy").

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

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

Ambulance Service means transportation to or from a Hospital or facility (includes mental facility) by a licensed ambulance when the vehicle transports for Emergency and non-emergency medical transportation.

Ambulatory Surgical Center means any public or private establishment: a) with an organized medical staff of Physicians; b) with permanent facilities that are equipped and operated primarily for performing surgical procedures; c) with continuous Physician services and registered professional nursing services whenever a patient is in the facility; d) which does not provide services or other accommodations for patients to stay overnight; and e) is duly licensed as an Ambulatory Surgical Center by the appropriate state authorities.

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.

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

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

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.

Covered Clinical Trials means phase I, phase II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:
1. Involve the treatment of life-threatening medical conditions,
2. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives,
3. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives.

Covered Clinical Trials must also meet the following requirements:
1. Must involve determinations by treating Physicians, relevant scientific data, and opinions of experts in relevant fields.
2. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.
3. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.
Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these. Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.) Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

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

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

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

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

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

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

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

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

Elective Treatment includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law.

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

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

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

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

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

Family Planning means counseling and education on available contraceptive methods and surgical procedures for sterilization as permitted by state and federal law, diaphragms, and coverage for other federal Food and Drug Administration approved devices and contraceptive drugs pursuant to the prescription drug benefit.

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 Services means medically necessary health care services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment.

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

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

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

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

For the purpose of Severe Mental Illness and Mental, Emotional, Nervous and Chemical Dependency Disorders only, Hospital includes an acute psychiatric Hospital as defined in subdivision (b) of Section 1250 of the California Health and Safety Code, a psychiatric health facility as defined by Section 1250.2 of the California Health and Safety Code operating pursuant to licensure by the State Department of Mental Health and a facility licensed to provide alcoholism or chemical dependency services under Chapter 2 (commencing with Section 1250 of Division 2 of the California Health and Safety Code).

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.

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.

Life-threatening Condition means that the Insured Person has a terminal condition or illness that according to current diagnosis has a high probability of death within two (2) years, even with treatment with an existing generally accepted treatment protocol.

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

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

Coverage for Low-Dose Screening Mammography shall be provided as follows:
1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true:
   a. The woman has a personal history of breast cancer;
   b. The woman has a personal history of biopsy-proven benign breast disease;
   c. The woman’s mother, sister, or daughter has or has had breast cancer; or
   d. The woman has not given birth prior to the age of 30;
2. One baseline mammogram for any woman 35 through 39 years of age, inclusive;
3. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Physician; and
4. A mammogram every year for any woman 50 years of age or older.

**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 Conditions** mean Mental or Nervous Disorders, Severe Mental Illness or Serious Emotional Disturbances of a Child.

**Mental or Nervous Disorder** means any nervous, emotional and mental disease, illness, syndrome, or dysfunction classified in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders on the date care or medical treatment is rendered. This includes, but is not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or mental disease caused by an organic condition, disease, illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others). It does not include Severe Mental Illness or Serious Emotional Disturbances of a Child.

**Multiple Project Assurance Contract** means a contract between an institution and the federal department of health and human services that defines the relationship of the institution to the federal department of health and human services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

**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.

**Non-emergency transportation** means the transfer of an Insured Person in a licensed ambulance and psychiatric transport van service when the vehicle transports the Insured Person to or from covered services and the use of other means of transportation may endanger the insured's health. This includes the transfer of an Insured Person from one hospital to another hospital or facility (includes mental health facilities) to home when the transportation is:
1. Medically necessary, and
2. Requested by a plan provider, and
3. Authorized in advance by the participating health plan.

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

**Orthotic Devices** means rigid or semi-rigid devices supporting a weak or deformed leg, foot, arm, hand, back or neck or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Benefits for Orthotic Devices include orthopedic appliances or apparatus used to support, align, prevent, or correct deformities or to improve the function of movable parts of the body. An Orthotic Device differs from a prosthesis in that, rather than replacing a body part, it supports and/or rehabilitates existing body parts. Orthotic Devices are usually customized for an Insured Person's use and are not appropriate for anyone else. Examples of Orthotic Devices include but are not limited to ankle Foot Orthosis (AFO), Knee Ankle Foot Orthosis (KAFO), Lumbosacral Orthosis (LSO).

**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 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.

**Post-Partum Period** means the 60 day period directly following the child's date of birth.

**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.

**Prosthetic Devices** (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for Prosthetic Devices include coverage of devices that replace all or part of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a Physician’s order. This benefit also covers prosthetic devices for post laryngectomy. Examples of Prosthetic Devices include but are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.
Reconstructive Breast Surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the non-diseased breast.

Rehabilitation Facility means a legally operating institution or distinct part of an institution which is primarily engaged in providing comprehensive, multidisciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, is duly licensed by the appropriate government agency to provide such services and is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities. It does not include institutions that provide only minimal care, Custodial Care, ambulatory or part-time care services.

Rehabilitation Services means those services which are designed to remediate an Insured Person’s condition or restore an Insured Person to his or her optimal physical, medical, psychological, social, emotional, vocational and economic status. Rehabilitation Services include by illustration and not limitation diagnostic testing, assessment, monitoring or treatment of the following conditions individually or in a combination: Stroke; Spinal cord injury; Congenital deformity; Amputation; Major multiple trauma; Fracture of femur; Brain injury; Polyarthritis, including rheumatoid arthritis; Neurological disorders, including, but not limited to, multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson’s disease; Cardiac disorders, including, but not limited to, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart transplantation, chronic arrhythmias, congestive heart failure, valvular heart disease; Burns. Rehabilitation Services do not include services for mental health, chemical dependency, vocational rehabilitation, long-term maintenance or custodial services.

Respite Care means short-term care given to a Hospice patient by another care-giver so that the patient’s care-giver can rest or take time off.

Serious Emotional Disturbances of a Child means one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders other than a primary Substance Use Disorder or developmental disorder, that result in behavior inappropriate to the child’s age according to expected developmental norms, and that meet one or more of the following criteria:
1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occurs: a) The child is at risk of removal from home or has already been removed from the home. b) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
2. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.
3. The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Serious Mental Illness means schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorder, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa. Severe Mental Illness does not include Mental or Nervous Disorder.

School or College means the college or university attended by the Insured Student.

Skilled Nursing Facility means a licensed facility that provides inpatient skilled nursing and is devoted to providing medical, nursing, or custodial care for an Insured Person over a prolonged period, such as during the course of a chronic disease or the rehabilitation phase after an acute sickness or injury. A Skilled nursing Facility may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

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.

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

Sterilization Operations or Procedures means any operation or procedure altering the human body which has as its purpose, or one of its purposes, the temporary or permanent prevention of procreation by either a male or a female.

Temporomandibular Disorder(s) means a group of musculoskeletal conditions, often overlapping, that involve the temporomandibular joint (TMJ) or joints, the masticatory musculature, or both. These conditions are typically characterized by pain in the preauricular area which is usually aggravated by chewing or jaw function, and are frequently accompanied, either singly or in combination, by limitation of jaw movement, joint sounds, palpable muscle tenderness or joint soreness. Although pain and dysfunction in the orofacial or craniofacial regions have multiple sources and etiologies that may coexist with temporomandibular disorders or show signs similar to those of temporomandibular disorders; temporomandibular disorders are limited to pain and dysfunction arising in and from the masticatory musculoskeletal system.
Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

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

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

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

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

SECTION 2 – ELIGIBILITY, ENROLLMENT AND TERMINATION

Menlo College requires all its eligible and enrolled traditional program students and International Students to be covered under the plan on a waiver participation basis.

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

Extension of Benefits: Coverage under the Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows: If an Insured Person is Hospital confined or receiving treatment 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 or treatment continues.

Continuous Coverage: Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under the Policy: 1) When premium payment is received either in Our Home Office or by Our Agent or the Plan Administrator; and 2) Premium is received within the Enrollment Period specified in the Insurance Information Schedule.

This is regardless of any breaks in calendar days between consecutive periods of insurance.

SECTION 3 — BENEFITS

Benefit Payment for Network Providers and Non-Network Providers - 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.

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.

Basic Injury and Sickness Benefit: If: 1. an Insured Person incurs expenses as the result of Covered Injury or Covered Sickness, then 2. We will pay the benefits stated in the Schedule of Benefits for the services, treatments and supplies described in the Covered Medical Expenses provision below.

Payment will be made, Subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits: 1. For the Usual and Reasonable Charges for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and 2. Subject to the Exclusions and Limitations provision.
Covered Medical Expenses
We will pay the Usual and Reasonable charges incurred for Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness. The Covered Medical Expenses for an issued Policy will be only those listed below and as shown in the Schedule of Benefits.

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

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

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.

SCHEDULE OF BENEFITS — PLATINUM PLAN

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

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

Deductible:
Network: $100
Non-Network: $300

Out-of-Pocket Expense Limit:
Network Provider: Individual: $6,350
Non-Network Provider: Individual: No maximum

Coinsurance Amount:
Network Provider: 90% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider: 70% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.

Benefit Payment for Network Providers and Non-Network Providers
The Policy provides benefits based on the type of health care provider selected. 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.

Hospital Inpatient Facility Copayment:
Network: $250
Non-Network: $250
<table>
<thead>
<tr>
<th>Benefits for Covered Injury/Sickness</th>
<th>In-Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Essential Health Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulatory/Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assistant Surgeon Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery Miscellaneous</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Outpatient Facility Fee</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Diagnostic X-ray and Therapeutic Radiologic Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Laboratory Procedures (Outpatient)</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Rehabilitation Therapy (outpatient)- including physical, occupational, speech and manipulative therapy (massage), Aquatic Therapy.</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Habilitative Services are covered to the extent that they are Medically Necessary Up to 30 visits per Policy Year</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Up to 30 visits per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dialysis Care</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Primary Care Visit to Treat an Injury or Illness</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Specialists Visit</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Other Practitioner Office Visit</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Outpatient Physician’s Visit</strong></td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Second Opinion Benefit</strong></td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Prenatal Care</strong></td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td><strong>Clinical Trials</strong></td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $40</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>EMERGENCY SERVICES</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Service</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expense</td>
<td>The PPO Allowance stated above</td>
<td>90% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>HOSPITALIZATION - INPATIENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Room &amp; Board Expense</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room &amp; Board Expenses</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Hospital Miscellaneous Expenses for Service &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic Service, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Preadmission Testing</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Physician’s Visits while Confined</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Service Description</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------</td>
<td>-------------</td>
</tr>
<tr>
<td>Inpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Assistant Surgeon Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Mastectomy Benefit and Reconstructive Breast Surgery</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Reconstructive Surgery Benefits</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Bariatric (Weight Loss) Surgery</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>General Anesthesia for Dental Procedures</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Organ Transplant</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Skilled Nursing Facility for up to Skilled Nursing Facility room rate per day</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>60 days per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care Coverage for up to 60 days</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Registered Nurse's Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Physical Therapy (inpatient)</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>MATERNITY AND NEWBORN CARE</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>On the same basis as any other Preventive Service</td>
<td>On the same basis as any other Preventive Service</td>
</tr>
<tr>
<td>Inpatient Physician charges or Surgeon charges</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Physician directed Follow-up Care</td>
<td>The PPO Allowance stated above</td>
<td>The PPO Allowance stated above</td>
</tr>
<tr>
<td>Maternity Pre-Natal Alpha Feto Protein Test (Expanded AlFP Program)</td>
<td>On the same basis as any other Covered Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Breast Feeding Support and Supplies</td>
<td>On the same basis as any other Covered Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>On the same basis as any other Covered Service</td>
<td>On the same basis as any other Covered Service</td>
</tr>
<tr>
<td>TRANSPORTATION OF NEWBORN TO AND FROM NEAREST MEDICAL FACILITY FOR TREATMENT: up to $200.00 of Usual and Reasonable Charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICE, INCLUDING BEHAVIORAL HEALTH TREATMENTS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>Mental/Behavioral Health Inpatient Services</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Substance Abuse Disorder Inpatient Detoxification Services</td>
<td>100% of PPO Allowance for Covered Medical Expense</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Mental/Behavioral Health Outpatient Services</td>
<td>100% of PPO Allowance for Covered Medical Expense</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Substance Abuse Disorder Outpatient Detoxification Services</td>
<td>100% of PPO Allowance for Covered Medical Expense</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Severe Mental Illness Benefits (SMI) or Serious Emotional Disturbances of a Child (SED)</td>
<td>100% of PPO Allowance for Covered Medical Expense</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>PRESCRIPTION DRUGS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>Prescription Drugs Includes injectable and specialty drugs</td>
<td>100% of Usual and Reasonable Charge for Covered Rx Expenses</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Includes injectable and specialty drugs</td>
<td>Copayment: $15 Generic</td>
<td>Copayment: $15 Generic</td>
</tr>
<tr>
<td>Includes injectable and specialty drugs</td>
<td>Copayment: $30 Preferred Brand</td>
<td>Copayment: $30 Preferred Brand</td>
</tr>
<tr>
<td>Includes injectable and specialty drugs</td>
<td>Copayment: $50 Brand</td>
<td>See Prescription Card</td>
</tr>
<tr>
<td>Service Description</td>
<td>Benefit Category</td>
<td>PPO Allowance</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Family Planning</td>
<td>Other Rx Expense</td>
<td>Same as any other Rx Expense</td>
</tr>
<tr>
<td>AIDS Vaccine</td>
<td></td>
<td>The PPO Allowance stated above</td>
</tr>
<tr>
<td>Drugs and Equipment for Pediatric Asthma Treatment</td>
<td>Same as any other Covered Sickness and Rx Expense</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Diabetic Drugs and Supplies</td>
<td>Same as any other Covered Sickness and Rx Expense</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>REHABILITATION AND HABILITATIVE SERVICE</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>Rehabilitation Therapy (Outpatient)</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Habilitative Service (Outpatient)</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Behavioral Health Treatment for Pervasive Developmental Disorder or Autism</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>Up to 30 visits per Policy Year</td>
<td>The PPO Allowance stated above</td>
</tr>
<tr>
<td>Prosthetic Devices for Post Laryngectomy</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Prosthetic and Orthotic Devices</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Special Shoe Benefit</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Mastectomy Benefit and Reconstructive Breast Surgery</td>
<td>Same as any other Covered Sickness</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Contact lenses to Treat Aniridia and Aphakia</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>LABORATORY SERVICE</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>Diagnostic Testing Service</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Specialty Diagnostic Service</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Breast Cancer Screening and Mammography</td>
<td>On the same basis as any other Preventive Services</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Prostate Cancer Screening</td>
<td>On the same basis as any other Preventive Services</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Colorectal Cancer Screening Benefit</td>
<td>On the same basis as any other Preventive Services</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Cervical Cancer Screening</td>
<td>On the same basis as any other Preventive Services</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>HIV Testing</td>
<td>On the same basis as any other Preventive Services</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Maternity Pre-Natal Alpha Feto Protein Testing</td>
<td>On the same basis as any other Preventive Services</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Osteoporosis Coverage/Bone Mass Measurement Benefit</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Preventive Service Covered without regard to any Deductible or Coinsurance requirement that would otherwise apply</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Service</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>------------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Examinations</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Well Woman Visits</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Well-Child Visits</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Routine Vision Screenings</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Lead Screenings (For Dependent Children)</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Allergy Services</td>
<td>100% of PPO Allowance for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Treatment of Covered Injury or Sickness</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Preventive Cancer Screening Tests</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Diabetes Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic Equipment and Supply Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Diethylstilbestrol (DES) Exposure Coverage</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phenylketonuria (PKU) Testing and Treatment Benefit</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Immunizations</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Pediatric Asthma Services</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expense Copayment: $20</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Comprehensive Pediatric Preventive Services</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
<tr>
<td>Hearing Screenings and Exams</td>
<td>On the same basis as any other Preventive Service</td>
<td>The Usual and Reasonable Charge stated above Deductible, Copays or Coinsurance will be applied when services are received from a Non-Network Provider</td>
</tr>
</tbody>
</table>

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### Pediatric Dental Care Benefit

<table>
<thead>
<tr>
<th>Benefit</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Dental Care</td>
<td>See Benefit for limitations 100%, limited to 2 dental exams every 12 months</td>
<td>See Benefit for limitations 100%, 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>Clinical Oral</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>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Pediatric Vision Care</td>
<td>100% of PPO for Covered Medical Expenses</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Limited to 1 visit(s) per Benefit Period</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Year and 1 pair of prescribed lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and frames</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Other Health Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acupuncture</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Non-emergency transportation</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Chemical Dependency Services</td>
<td>Same as any other Covered Sickness</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Durable Medical Equipment for Home Use</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Organ Donation Service</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Ostomy, Urinary Supplies</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Prenatal Diagnosis of Genetic Disorders of</td>
<td>Same as any other Covered Sickness</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>the Fetus</td>
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### AMBULATORY/OUTPATIENT BENEFITS

**Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** - We will pay benefits for outpatient surgery (including fees for pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the outpatient surgery benefit or the inpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value and 10-50% for the second procedure. We will pay 10-25% for any additional procedures. Outpatient Surgery does not include coverage for removal of wisdom teeth, whether or not imbedded in bone.

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

**Outpatient Facility Fee** – We will pay the expenses for outpatient facilities, including an ambulatory surgical center, for outpatient surgeries and procedures not including: removal of wisdom teeth whether or not imbedded in bone.

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

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

**Rehabilitation Therapy (Outpatient)** – We will pay the expenses incurred for a physical therapy, speech/language therapy, occupational therapy, or an organized program of these combined services when provided by a physical therapist, an occupational therapist, a licensed speech-language pathologist, or a recognized expert in specialty pediatrics. Both Aquatic Therapy and Massage Therapy are covered if prescribed as part of a physical therapy treatment plan. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

**Habilitative Services (Outpatient)** - We will pay the Usual and Reasonable expenses incurred for medically appropriate and necessary services that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual’s environment. Habilitative Services provide the same services and under the same terms and conditions as the Rehabilitation Therapy benefit.

**Home Health Care Services** - We will pay the charges incurred for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary. We cover up to two (2) hours per visit or three (3) hours for home health aide. Three visits per day. Home Health Care visits related to maternity care will be payable under the Maternity Benefit and not this Benefit.
Dialysis Care - Dialysis care is covered for Medically Necessary treatment of kidney disease or failure.

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

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

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

Outpatient Physician's Visits: We will be covered the same as for any other Covered Sickness. We will pay the expenses incurred for Physician's office visits, including visits by licensed registered nurses and licensed physician’s assistants. 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. Visits are for treatment of a Covered Sickness or Covered Injury or as otherwise required as a Preventive Service.

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

Second Opinion Benefit: We will pay the Usual and Reasonable expenses incurred for a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:
1. If the Insured Person questions the reasonableness or necessity of recommended surgical procedures;
2. If the Insured Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;
3. If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the insured requests an additional diagnosis;
4. If the treatment plan in progress is not improving the medical condition of the Insured Person within an appropriate period of time given the diagnosis and plan of care, and the insured requests a second opinion regarding the diagnosis or continuance of the treatment;
5. If the Insured Person has attempted to follow the plan of care or consulted with the initial physician concerning serious concerns about the diagnosis or plan of care.

Prenatal Care will be covered for services received by a pregnant female in a Physician’s, obstetrician’s, or gynecologist’s office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Prenatal Care will be covered for services received by a pregnant female in a Physician’s, obstetrician’s, or gynecologist’s office but only to the extent described below. Coverage for prenatal care under this benefit is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).

Clinical Trials Benefit: We will pay the Usual and Reasonable expenses incurred for Medically Necessary Health Care Services provided while an Insured Person is participating in a Covered Clinical Trials. Benefits do not include the costs of services that are not Health Care Services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the Insured Person. In the event a claim contains charges related to services for which coverage is required under this Benefit and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this Benefit, We may deny the claim.

EMERGENCY SERVICES

Emergency Services Expense: Only in connection with care for an Emergency Medical Condition 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.

We will also pay for Cancer Clinical Trials the same as any other Covered Sickness for all routine patient care costs related to the clinical trial diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer. For purposes of this section, a clinical trial’s endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

For Purposes of this benefit, “Routine patient care costs” means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program

Urgent Care: We will pay the expenses incurred for Urgent Care as shown in the Schedule of Benefits. Urgent Care is medical, surgical, maternity (your unborn child), or psychiatric care that is needed right away to prevent serious deterioration of health when an unforeseen illness or injury occurs. In most cases, Urgent Care will be brief diagnostic care and treatment to stabilize.

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

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

Hospital Intensive Care Unit Expense – in lieu of normal Hospital Room & Expenses, including 24-hour nursing care. This benefit is NOT payable in addition to room and board charges incurred on the same date.

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

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

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

Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services – We will pay benefits for inpatient surgery (including pre- and post-operative visits) as specified in the Schedule of Benefits. Human Organ Transplants are covered as any other surgical procedure. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician’s visits. If the surgical procedure is for a Medically Necessary human to human organ transplant or a bone marrow procedure, We will also pay for transportation, lodging, and meal expenses for the Insured Person and one Immediate Family Member $150 per day for up to $10,000 per episode (time from initial evaluation until the sooner of discharge or cleared to return home).

Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit - We will pay the Usual and Reasonable expenses incurred for surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jawbone, or associated bone joints of an Insured Person. This benefit does not include the provision of dental services.

Mastectomy Benefit and Reconstructive Breast Surgery - We will pay the Usual and Customary expenses incurred for mastectomy performed while an inpatient, including coverage for post-mastectomy inpatient care. The decision to discharge the Insured Person following mastectomy must be made by the attending Physician in consultation with the Insured Person, and shall further ensure that the length of post-mastectomy hospital stay is based on the unique characteristics of each Insured Person taking into consideration the health and medical history of the Insured Person. We will also pay the Usual and Customary expenses incurred for Reconstructive Breast Surgery following a mastectomy. The coverage shall include coverage for all stages and revisions of Reconstructive Breast Surgery performed on a non-diseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and reconstruction, subject to the approval of the treating Physician.

Reconstructive Surgery Benefits: We will pay the Usual and Reasonable expenses incurred for reconstructive surgery including surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection or disease to do either of the following: 1) To improve function; 2) To create a normal appearance, to the extent possible. 3) The definition also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

Cleft palate means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

Bariatric (Weight Loss) Surgery Benefit: Bariatric surgery is covered for the treatment of morbid obesity when determined to be Medically Necessary. We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Physician Services. Completion of the pre-surgical educational preparatory program is required before surgery is approved. A transportation benefit is covered if Insured Person must travel more than 50 miles from facility to which patient is referred.

General Anesthesia for Dental Procedures: Benefits are payable for general anesthesia and associated facility charges for dental procedures rendered in a Hospital or Ambulatory Surgical Center setting, when the clinical status or underlying medical condition requires dental procedures that ordinarily would not require general anesthesia to be rendered in a Hospital or Ambulatory Surgical Center, for children below the age of 7 years, persons who are developmentally disabled regardless of age, and persons whose health is compromised and for whom general anesthesia is Medically Necessary regardless of age. Charges for the dental procedure itself (including the professional fee of the dentist) are not covered.

Organ Transplant: Benefits are payable for human organ transplant or tissue transplant or replacement. However, the only human organ transplants eligible for this benefit are those that are not considered Experimental.
An Insured Person may be directed to a facility designated by Us as a Transplant Network for certain services. If the Insured Person agrees to use the Transplant Network to which We direct the Insured Person, We will provide benefits for the Insured Person’s transportation to and from the Transplant Network for the initial treatment, evaluation and for the resulting confinement.

If the Insured Person receives a covered human organ or tissue transplant, the donor’s expenses will be considered to be the Insured Person’s expenses even if the donor is also insured under the Policy as an Employee or Dependent. We will pay benefits for the donor’s Covered Charges to the extent an actual charge is made that is not paid or payable by any other plan covering the donor.

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

**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.

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

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

**MATERNITY AND NEWBORN CARE**

**Maternity Benefit** - We will pay the expenses incurred for maternity charges as follows: 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.

**Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

**Physician-directed Follow-up Care** including: 1) Physician assessment of the mother and newborn; 2) Parent education; 3) Assistance and training in breast or bottle feeding; 4) Assessment of the home support system; 5) Performance of any prescribed clinical tests; and 6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in "Hospital Stays", 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.

**Maternity Pre-Natal Alpha Feto Protein Testing:** Professional and hospital services relating to maternity care including pre-natal and postpartum care and complications of pregnancy, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy, labor and delivery care, newborn examinations and nursery care while the mother is hospitalized, and for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

**Breast Feeding Support and Supplies**: covered medical expense will include comprehensive lactation support (assistance and training in breast feeding) and counseling services provided to females during pregnancy and in the post-partum period by a certified lactation support provider. Covered expenses incurred during the post-partum period also include the rental or purchase of breast feeding equipment. Lactation support and lactation counseling services are covered expenses when provided in either a group or individual setting.

**Routine Newborn Care** - If expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefits 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) Charges made by a Physician in connection with a circumcision; d) Routine laboratory tests including lead screening; e) Postpartum home visits prescribed for a newborn; f) Follow-up office visits
for the newborn subsequent to discharge from a Hospital; and g) 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.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT

Mental/Behavioral Health Inpatient and Outpatient Services: We will pay the Usual and Reasonable expenses incurred on an Inpatient and Outpatient basis for treatment of Mental and Behavioral Health disorders – as identified in DSM and as shown in the Schedule of Benefits. Such treatments must be performed by a licensed Physician or psychologist. Treatment may be performed in an office, Hospital or in a community mental health facility that is approved by the Joint Commission on Accreditation of Health Care Organizations, the Council on Accreditation for Children and Family Services or certified by the State Department of Mental Health. Inpatient psychiatric hospitalization is covered as stated in the Hospital Inpatient section of the Policy.

The treatments and services under the clinical supervision of a licensed Physician or psychologist must meet both of the following requirements: a) The services must be performed in accordance with a treatment plan that describes the expected duration, frequency and type of services performed; and b) The plan of treatments must be reviewed and approved by a licensed Physician or psychologist every three months.

Substance Abuse Disorder Inpatient and Outpatient Detoxification Services: We will pay expenses incurred on and inpatient and outpatient basis for Chemical Dependency Services including individual and group counseling and medical treatment for withdrawal symptoms. This includes transitional residential recovery services.

Severe Mental Illness Benefits (SMI) or Serious Emotional Disturbances of A Child (SED): Your coverage includes benefits for severe mental illness (adults and children) and serious emotional disturbances of children including: schizophrenia, schizoaffective disorder, bipolar disorder (manic depressive illness), major depressive disorder, panic disorder, obsessive compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

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. Benefits include hypodermic needles or syringes required for the administration of a prescription drug.

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: a) The drug is approved by the FDA; b) The drug is prescribed for the treatment of a life-threatening condition including but not limited to cancer or human immunodeficiency virus or acquired immunodeficiency syndrome (AIDS/HIV); 1) The drug has been recognized for treatment of that condition by one of the following: The American Medical Association Drug Evaluations; 2) The American Hospital Formulary Service Drug Information. 3) The United State Pharmacopoeia Dispensing Information, volume 1, “Drug Information for Health Care Professionals”; or 4) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items i., ii., and iii. of this benefit.

As it pertains to this benefit, life threatening means either or both of the following: 1) Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or 2) Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival. 3) Specialty Drugs - “Specialty Drugs” are Prescription Drugs which:

- Are only approved to treat limited patient populations, indications, or conditions; or
- Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or
- 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.

Step Therapy - When medications for the treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us within forty-eight (48) hours, if all necessary information to perform the override review has been provided, under the following documented circumstances: a) The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first protocol has been ineffective in the treatment of the Insured Person’s disease or medical condition; or b) Based on sound clinical evidence or medical and scientific evidence:

(a) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

(b) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the Insured Person.
The duration of any step therapy or fail-first protocol shall not be longer than a period of thirty (30) days if the treatment is deemed and documented as clinically ineffective by the prescribing practitioner. When the prescribing practitioner can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief or an amelioration to the insured, the step therapy or fail-first protocol may be extended up to seven (7) additional days.

**Family Planning Contraceptive Methods (includes Sterilization)** includes coverage for a variety of federal Food and Drug Administration (FDA) approved prescription contraceptive methods and surgical procedures for sterilization as permitted by state and federal law as designated by the insurer. If the health care provider does not think that the method requested by Insured Person is medically appropriate for the Insured Person’s medical or personal history, the insurer shall, in the alternative, provide coverage for some other FDA approved prescription contraceptive method prescribed by the patient’s health care provider.

**AIDS Vaccine**: We will cover vaccination for acquired immune deficiency disorder that is recommended by the United States Public Health Service.

**Diabetic Drugs and Supplies**: Prescription Drugs for the treatment of diabetes (including insulin) are covered as stated in the Formulary. Nebulizers (including face masks and tubing) are covered under the medical benefit under Durable Medical Equipment.

**Prosthetic and Orthotic Devices**: Benefits for Prosthetic Devices include coverage of devices that replace all or part of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a Physician’s order. This benefit also covers prosthetic devices for post laryngectomy.

**Prosthetic and Orthotic Devices** – We will pay the expenses incurred for Prosthetic and Orthotic Devices that are Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience. Benefits include coverage of all services and supplies Medically Necessary for the effective use of a Prosthetic or Orthotic Device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the Insured Person in the use of the device. Benefits also include coverage for ostomy and urological supplies and any repair or replacement of a Prosthetic or Orthotic Device that is determined Medically Necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that is not solely for comfort or convenience.

**Special Shoe Benefit**: We will pay the Usual and Reasonable expenses incurred for special footwear as needed by Insured Persons who suffer from foot disfigurement, including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or development disability.
Mastectomy Benefit and Reconstructive Breast Surgery: We will pay the Usual and Customary expenses incurred for a mastectomy performed while an inpatient, including coverage for post-mastectomy inpatient care. The decision to discharge the Insured Person following mastectomy must be made by the attending Physician in consultation with the Insured Person, and shall further ensure that the length of post-mastectomy hospital stay is based on the unique characteristics of each Insured Person taking into consideration the health and medical history of the Insured Person. We will also pay the Usual and Customary expenses incurred for Reconstructive Breast Surgery following a mastectomy. The coverage shall include coverage for all stages and revisions of Reconstructive Breast Surgery performed on a non-diseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and reconstruction, subject to the approval of the treating Physician.

Contact Lenses to Treat Aniridia and Aphakia: We will cover Routine non-pediatric eye exam services for refraction to determine the need for vision correction and provide a prescription for eyeglass lenses, but not excluding examination of the eye for other purposes, including preventive screening for conditions such as hypertension, diabetes, glaucoma, or macular degeneration.

We will pay the Usual and Customary expenses incurred for special contact lenses to treat aniridia and aphakia when prescribed by a Physician or Optometrist.

Durable Medical Equipment - We will pay the expense incurred for Durable Medical Equipment for home use and prosthetic and orthotic devices for rental or purchase, including, but not limited to: 1. Diabetic Shoes and Inserts: off-the-shelf depth-inlay shoes; custom-molded shoes; custom-molded multiple density inserts; fitting, modification, and follow-up care for podiatric devices; repair or replacement of podiatric devices. 2. Glucose Monitors, Infusion Pumps, and Related Supplies: external single or multiple channel electric or battery-operated ambulatory infusion pumps; home blood glucose monitors; blood glucose test or reagent strips for home blood glucose monitors; interstitial glucose monitors; programmable and non-programmable implantable infusion pumps; infusion pump used for uninterrupted parenteral administration of medication; infusion sets for external insulin pumps; infusion supplies for external drug infusion pumps; lancets; calibrator solution/chips; single or multi-channel stationary parenteral infusion pumps; replacement batteries for home blood glucose monitors and infusion pumps; spring-powered device for lancing; syringe with needle for insulin pump. 3. Respiratory Drug Delivery Devices: large and small volume nebulizers; disposable and non-disposable administration sets; aerosol compressors; aerosol mask; disposable and non-disposable corrugated tubing for nebulizers; disposable and non-disposable filters for aerosol compressors; peak expiratory flow rate meter; distilled water for nebulizer; water collection device for nebulizer. 4. Tracheostomy Equipment: artificial larynx; replacement battery for artificial larynx; tracheo-esophageal voice prosthesis; tracheostomy supplies, including: adhesive disc, filter, inner cannula, tube, tube plug/stop, tube collar/holder, cleaning brush, mask, speaking valve, gauze, sterile water, waterproof tape, and tracheostomy care kits. 5. Canes and Crutches: adjustable and fixed canes; standard curved handle and quad canes; adjustable and fixed crutches, including underarm and forearm crutches; replacement supplies for canes and crutches, including handgrips, tips, and underarm pads. 6. Dry pressure pad for a mattress. 7. Cervical traction equipment (over door). 8. Osteogenesis Stimulation Devices: non-invasive electrical osteogenesis stimulators, for spinal and non-spinal applications; non-invasive low density ultrasound osteogenesis stimulator. 9. Enteral and Par-enteral Nutrition: enteral formula and additives, adult and pediatric, including for inherited diseases of metabolism; enteral feeding supply kits; enteral nutrition infusion pump; enteral tubing; gastrostomy/jejunostomy tube and tubing adaptor; nasogastric tubing; parenteral nutrition infusion pump; parenteral nutrition solutions; stomach tube; supplies for self-administered injections. 10. Hospital grade breast pump and double breast pump kit. 11. IV pole. 12. Phototherapy (bilirubin) light with photometer. 13. Compression burn garment; lymphedema gradient compression stocking; light compression bandage; manual compression garment; moderate compression bandage. 14. Non-segmental home model pneumatic compressor for the lower extremities. 15. Prosthetic Devices for Mastectomy: prosthetic devices incident to a mastectomy, including custom-made prostheses when medically necessary; adhesive skin support attachment for use with external breast prosthesis; and brassieres for breast prostheses. 16. Prosthetic devices to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect. Hospital beds, wheelchairs, 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.

LABORATORY SERVICES

Diagnostic Testing Services: We will pay for diagnostic tests including related professional fees, incurred on a non-Inpatient basis. Diagnostic tests include x-rays, laboratory tests, electrocardiograms (EKGs) and electroencephalograms (EEGs).

Specialty Diagnostic Specialty Services: We will pay for specialty diagnostic tests, and including related professional fees, incurred on an Outpatient basis. Specialty Diagnostic Tests include nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), angiography, arthroscopy, cholangiography, choledochography, cytourethroscoppy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreateography, vasography, or venography.

Breast Cancer Screening-Mammography: We will pay the Usual and Reasonable expenses incurred Low-dose Screening Mammography. Coverage for low-dose screening mammography shall be provided as follows: 1. One or more mammograms a year, as recommended by a Physician, for any woman who is at risk for breast cancer. For purposes of this subdivision, a woman is at risk for breast cancer if any one or more of the following is true the woman has a personal history of breast cancer; the woman has a personal history of biopsy-proven benign
breast disease; the woman’s mother, sister, or daughter has or has had breast cancer; or the woman has not given birth prior to the age of 30; 2. One baseline mammogram for any woman 35 through 39 years of age, inclusive; 3. A mammogram every other year for any woman 40 through 49 years of age, inclusive, or more frequently upon recommendation of a Physician; and 4. A mammogram every year for any woman 50 years of age or older.

Reimbursement for a mammogram authorized under this section shall be made only if the facility in which the mammogram was performed meets mammography accreditation standards established by California laws and regulations.

**Prostate Cancer Screening: Prostate-Specific Antigen (PSA) tests or Equivalent Tests for the Presence of Prostate Cancer** means serological tests for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

**Colorectal Cancer Screening Benefit:** We will pay the Usual and Reasonable expenses incurred for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by California laws and regulations for colorectal screening, for any nonsymptomatic Insured Person who is: 1. At least 50 years of age; or 2. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society or guidelines adopted by California laws and regulations.

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

Coverage for the screening for the early detection of cervical cancer shall be in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by California laws and regulations on Cancer Coordination and Control. Coverage shall include the examination, the laboratory fee, and the Physician’s interpretation of the laboratory results. Reimbursements for laboratory fees shall be made only if the laboratory meets accreditation standards adopted by California laws and regulations.

**HIV Testing:** We will cover the recommended screening for the human immunodeficiency virus (HIV) screenings, regardless of whether the testing is related to a primary diagnosis.

**Maternity Pre-Natal Alpha Feto Protein Testing:** Professional and hospital services relating to maternity care including pre-natal and postpartum care and complications of pregnancy, prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy, labor and delivery care, newborn examinations and nursery care while the mother is hospitalized, and for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

**Osteoporosis Coverage/Bone Mass Measurement Benefit:** We will pay the Usual and Reasonable expenses incurred for an Insured Person who is a Qualified Individual for scientifically proven and approved Bone Mass Measurement for the diagnosis and evaluation of osteoporosis or low bone mass. We will only pay for a Bone Mass Measurement every 23 months, unless a Physician determines that a more frequent measurement is Medically Necessary as follows. Conditions under which more frequent Bone Mass Measurement coverage may be Medically Necessary include, but are not limited to: 1. Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months; or 2. Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

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**PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT**

**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 (Well-Child visit). 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. 5) Preventive Services and Supplies include, but are not limited to annual preventive physical examinations, immunizations, well-woman examinations, preventive services for pregnancy, other women’s preventive services as supported by the health Resources and Services Administration (HRSA), and preventive vision and hearing screening examinations. 6) Routine Vision Care for Insured Persons over 18 includes routine eye exams for refraction and preventive vision screenings once every benefit year. 7) Hearing Screenings and Exams: We will pay the Usual and Reasonable expenses incurred for examinations for hearing tests, and audiological evaluations to measure the extent of hearing loss and a hearing aid evaluation. 8) Lead Screenings are included and payable for the screening of Dependent children who are Insured Persons to determine the lead levels contained in the blood. 9) **Allergy Services** are covered and payable and include allergy testing and allergy injections.
If an Insured Person receives any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, he or she will also pay the applicable Copayment or Coinsurance for those services.

**Treatment of Covered Injury or Covered Sickness:** We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to Covered Injury or Covered Sickness. Benefits payable are subject to: 1. Any specified benefit maximum amounts; 2. Any Deductible amounts; 3. Any Coinsurance amount; 4. Any Copayments; 5. The Maximum Out-of-Pocket Expense Limit and 6. Use of a network Provider, if any.

The following are shown in the Schedule of Benefits: 1. Deductible; 2. Any specified benefit maximums; 3. Coinsurance percentages; 4. Copayment amounts; 5. Out-of-Pocket Expense Limits.

The Covered Medical Expenses for an issued Policy will be only those listed in Covered Medical Expenses with all applicable Deductibles, Coinsurance and Copayment amounts, and maximums for each benefit shown in the Schedule of Benefits.

The total benefit payable for all Covered Medical Expenses resulting from Covered Injuries and Covered Sicknesses will never exceed the Maximum Benefit shown in the Schedule of Benefits. We will not pay for expenses incurred that do not meet the definition of Covered Medical Expense.

**Preventive Cancer Screening Tests:** Benefits are payable for all generally medically accepted cancer screening tests specified in the Schedule of Benefits including cervical pap smear, prostate cancer screening and colorectal cancer screening.

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

**Diabetic Equipment and Supply Services:** We will pay for Prescription Drugs for the treatment of diabetes (including insulin) and Supplies as outlined in the Prescription Drugs section, under the **Diabetic Drugs and Supplies** paragraph in this Certificate.

**Osteoporosis:** We will provide coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis. The services may include, but need not be limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

**Diethylstilbestrol (DES) Exposure Coverage:** Conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol are covered without reduction of services, or other limitations.

**Phenylketonuria (PKU) Testing and Treatment Benefit:** We will pay the Usual and Reasonable expenses incurred for special dietary formulas and special food products for the therapeutic treatment of an Insured Person for phenylketonuria provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria.

**PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE**

**Pediatric 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. 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.

**Pediatric Asthma Services** are included in the outpatient prescription drug benefits includes coverage for medically prescribed inhaler spacers, nebulizers and other equipment and supplies as outlined in the Durable Medical Equipment benefit for the management and treatment of pediatric asthma.

**Comprehensive Pediatric Preventive Services:** We provide benefit coverage for the comprehensive preventive care of children 16 years of age or younger consistent with the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

We will comply with the most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Health Services determines, within 45 days of the published date of the schedule.

The following services are covered: (A) Periodic health evaluations. (B) Immunizations. (C) Laboratory services in connection with periodic health evaluations.

**Hearing Screenings and Exams:** Hearing Services: Includes hearing testing, an audiological evaluation to measure the extent of hearing loss and a hearing aid evaluation

**Pediatric Dental Care Benefit:** We will pay the Usual and Reasonable expenses incurred for Routine Dental Care for Dependent Children up to age 19. Dental Care for Insured Students and Dependent Children up to age 19.
1. Emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

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

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

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

5. 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:
   • 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
   • 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.

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

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

a. Vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination 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:

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

c. Prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic and includes treatment of Aphakia. 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.
OTHER HEALTH BENEFITS

Acupuncture: Benefits are payable for nausea or neuromuscular-skeletal Disorders, provided that the condition may be appropriately treated by a qualified Acupuncturist in accordance with professionally recognized standards of practice and is part of a comprehensive pain management program.

Non-emergency transportation is a covered benefit when a licensed ambulance and psychiatric transport van service is required and the vehicle transports an Insured Person to or from covered services and the use of other means of transportation may endanger the insured's health. This includes the transfer of an Insured Person from one hospital to another hospital or facility (includes mental health facilities); to home when the transportation is Medically Necessary, requested by a plan provider, and authorized in advance.

Chemical Dependency Services which shall be in compliance with federal parity requirements set forth in the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”), as follows:
(A) Inpatient detoxification -Hospitalization for medical management of withdrawal symptoms, including room and board, physician services, drugs, dependency recovery services, education, and counseling.
(B) Outpatient evaluation and treatment for chemical dependency:
   (i) Day-treatment programs;
   (ii) Intensive outpatient programs,
   (iii) Individual and group chemical dependency counseling; and
   (iv) Medical treatment for withdrawal symptoms.
(C) Transitional residential recovery- Chemical dependency treatment in a nonmedical transitional residential recovery setting. This setting provides counseling and support services in a structured environment.
(D) Chemical dependency services exclusion -Services in a specialized facility for alcoholism, drug abuse, or drug addiction are not required to be covered except as otherwise specified above.

Durable Medical Equipment for Home Use
(A) In addition to durable medical equipment otherwise required to be covered by the Act, the plan shall cover durable medical equipment for use in the enrollee’s home (or another location used as the enrollee’s home). Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured and appropriate for use in the home. The plan covers Durable Medical Equipment as stated in the Durable Medical Equipment section of the Policy.

Organ Donation Services are covered for actual or potential living donors, in addition to transplant services of organs, tissue, or bone marrow required as follows:
1. Coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is an enrollee.
2. Services must be directly related to a covered transplant for the enrollee, which shall include services harvesting the organ, blood evaluations and transfusions.
3. Donor is covered for up to 90 days following the harvest and evaluation services.

Treatment of donor complications related to stem cell donations, blood screening for stem cell donations and any issues caused by donor’s non-compliance with Physician’s orders and/or treatment plan.

Ostomy, Urinary Supplies: We will pay the Usual and Reasonable expenses incurred for Medically Necessary ostomy and urinary supplies for treatment of a Covered Injury or Sickness. Ostomy and urological supplies include, but are not limited to the following:
Adhesives, catheter supplies skin wash, bedside drainage bag bottles, incontinence supplies for hospice patients, disposable under pads and adult incontinence garments and all other supplies and devices to comply with Physician’s orders. This benefit does not include supplies that are comfort, convenience, or luxury equipment or features.

Prenatal Diagnosis of Genetic Disorders of the Fetus: Benefits are payable for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in the event of a high risk Pregnancy including tests for which genetic counseling is available.

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.
- **International Students Only** - expenses incurred within the Insured Person’s Home Country or country of regular domicile.
- **International Students Only** - Eligible expenses within the Insured Person’s 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.
- 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.
• 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 Policy.
• professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
• services or supplies not necessary for the medical care of the Insured Person’s Injury or Sickness.
• services or supplies hearing aids, except those resulting from a covered accidental Injury or as specifically covered under the Policy.
• weak, strained or flat feet, corns, calluses or ingrown toenails.
• birth control, including elective surgical procedures or devices, except as specifically provided in the Schedule of Benefits or as required under law.
• 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.
• expenses covered under any Workers’ Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
• 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.
• treatment of Outpatient Services for Substance Abuse Disorders or Nervous, Mental or emotional Disorders, treatment of alcoholism or drug addiction in specialized facilities that are not provided for in the Schedule of Benefits and Evidence of Coverage.
• any expenses in excess of Usual and Reasonable charges.
• 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.
• 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.
• loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate, intramural or club sports.
• Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;
• intentionally self-inflicted Injury, attempted suicide, or suicide, while sane or insane.; +
• 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.
• services that are duplicated when provided by both a certified nurse-midwife and a Physician.
• expenses payable under any prior Policy which was in force for the person making the claim.
• expenses incurred during a Hospital emergency room visit which is not of an emergency nature.
• 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.
• 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.
• Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
• charges incurred for acupuncture, physical therapy, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
• expenses for weight increase or reduction except Medically Necessary bariatric surgery, and hair growth or removal unless otherwise specifically covered under the policy.
• 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.
• 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.
• expenses incurred for Plastic or Cosmetic Surgery, unless needed to repair conditions resulting from an accidental Injury or for the improvement of the physiological functioning of a malformed body member, except for services related to orthognathic surgery, osteotomy or any other form of oral surgery, dentistry, or dental processed to the teeth and surrounding tissue.
• 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) In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be covered unless such care and services are performed solely and directly as a result of a Medically Necessary mastectomy.
• 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 definition in this Certificate 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 or to services specifically covered under the Policy.
• 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.
• elective abortions in excess of the amount shown in the Schedule of Benefits.
• allergy testing or treatment.
• congenital defects, except as provided for newborn or adopted children added after the Effective Date of coverage.
• custodial care service and supplies.
• hernia, of any kind.
• expenses that are not recommended and approved by a Physician.
• act of terrorism.
• conditions due to accidental bodily injury occurring prior to the Insured Person’s effective date of coverage.
• Respite care, day care, recreational care, residential treatment, social services, custodial care or education services of any kind do not qualify as habilitative services.
• Vision therapy, eyeglasses, contact lenses and surgical procedures for the correction of visual acuity in lieu of eyeglasses or contact lenses (except for intraocular lenses in connection with cataract removal)
• Home Health Care Services that an unlicensed family member or layperson could provide safely/Effectively or care in home if home is not safe and not an effective treatment setting.

SECTION 5—CLAIM PROCEDURE

In the event of an Injury or Sickness:
1. A claim form is not required to submit a claim. However, an itemized bill, HCFA 1500, or UB92 form should be used to submit expenses. If a referral was required, this form should accompany this submission. The Insured Student/Person’s name and identification number need to be included.
2. Providers should submit claims within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting the claim, a copy should be retained and claims should be mailed to the Claims Administrator, Commercial Travelers at the address above.
3. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Commercial Travelers Mutual Insurance Company.
4. If you disagree with a claim payment decision, an Insured Person has the right to file an appeal. The process for filing an appeal can be found in the Appeals Procedure section of this Certificate.

GENERAL POLICY PROVISIONS

Notice of Claim: Written notice of claim must be given to Our designated agent or Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at 70 Genesee Street - Utica, New York 13502, or to any authorized agent of Ours, with information sufficient to identify the Insured Person shall be deemed notice to Us.

Claim Forms: We, upon receipt of a written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing proofs of loss. If such forms are not furnished within 15 days after the giving of such notice the claimant shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proofs of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be furnished to Us within 90 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Insured Person, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Indemnities payable under this will be paid immediately upon receipt of due written proof.

Grace Period: A grace period of 31 days will be granted for the payment of premiums accruing after the first premium, during which grace period the Policy shall continue in force, but the Policyholder shall be liable to Us for the payment of the premium accruing for the period the Policy continues in force.

Payment of Claims: Indemnity for loss of life will be payable in accordance with the beneficiary designation and the provisions respecting such payment which may be prescribed herein and effective at the time of payment. If no such designation or provision is then effective, such indemnity shall be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person’s death may, at Our option, be paid either to such beneficiary or to such estate. All other indemnities will be payable to the Insured Person.

If any indemnity of the Policy shall be payable to the estate of the Insured Person, or to an Insured Person or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the insured employee or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.
Subject to any written direction of the Insured Person in an application or otherwise all or a portion of any indemnities provided by the Policy on account of hospital, nursing, medical or surgical service may, at the insurer’s option, and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

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

Physical Examination and Autopsy: We, at our own expense shall have the right and opportunity to examine the person of any individual whose injury or sickness is the basis of claim when and as often as it may reasonably require during the Pendency of a claim hereunder and to make an autopsy in case of death, where it is not forbidden by law.

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

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

SECTION 7—APPEALS PROCEDURE
You have the right to appeal any decision or action taken by Us to deny, reduce, or terminate the provision of or payment for health care services requested or received under this Certificate of Insurance. You have the right to have Our decision reviewed by an independent review organization. We must provide you with certain written information, including the specific reason for Our decision and a description of Your appeals rights and procedures every time We make a determination to deny, reduce, or terminate the provision of or payment for health care services requested or received under this Certificate of Insurance.

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

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

   An external review may be requested within 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 and contact information for the assigned independent review organization or the appropriate regulatory contact person
      ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn’t apply to expedited request or external reviews that involve an experimental or investigational treatment.
   b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.

5. We will not afford the Insured Person an external review if:
   a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   b. The Insured Person has failed to exhaust Our internal review process; or
   c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

   If We deny a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, We will notify the Insured Person in writing:
   a. The reason for the denial; and
   b. That the denial may be appealed to the Commissioner of Insurance.
6. 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.

Right to External Independent Medical Review

An Insured Person may apply to the Department of Insurance for an External Independent Medical Review when the Insured Person receives a Final Adverse Benefit Determination which denies, modifies, or delays health care services based, in whole or in part, on a finding that the disputed health care services are not Medically Necessary or are not Covered Medical Expenses under the Policy. The Insured’s request for an External Independent Medical Review must be submitted to the Department within six months after the Insured Person receives the Final Adverse Benefit Determination notice. However, the Commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

As part of its notification to the Insured regarding a disposition of the Insured’s Final Adverse Benefit Determination, the Company shall provide an application form approved by the Department, and an addressed envelope, which the Insured may return to initiate an External Independent Medical Review.

Requests for External Independent Medical Review shall be submitted to the state insurance department at the following address:

California Department of Insurance
Health Claims Bureau, IMR Unit
300 S. Spring Street, 11th Floor
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641

Questions Regarding Appeal Rights

Contact Customer Service at 800-756-3702 with questions regarding the Insured’s rights to an Internal Appeal and External Independent Medical Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

Department of Managed Health Care Help Center
980 Ninth Street, Suite 500
Sacramento, CA 95814-2725
Toll-Free: 1-888-466-2219
Fax: 1-916-255-5241
Website: www.healthhelp.ca.gov
Email: helpline@dmhc.ca.gov
Agent
Gallagher Student Health and Special Risk
500 Victory Road • Quincy, MA 02171
1-844-484-0088
Email: menlostudent@gallagherstudent.com or www.gallagherstudent.com/menlo

Underwritten by:

Administered by:
Commercial Travelers College Claim Department
70 Genesee Street, Utica, NY 13502
1-800-756-3702 • www.studentplanscenter.com
Electronic Claim Payor ID #: 88091

For a copy of the Company’s privacy notice you may:
go to www.commercialtravelers.com/privacy.html
or Request one from your school
or Request one from:
Commercial Travelers Mutual Insurance Company, c/o Privacy Officer, 70 Genesee Street, Utica, NY 13502
(Please indicate the school you attend with your written request.)

Network Provider:
First Health
1-800-336-5116

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.
The following services are not part of the Plan Underwritten by National Guardian Life Insurance Company. These value added services are provided by On Call International.

ON CALL INTERNATIONAL Global Assistance Program

The Global Assistance Program (GAP) is supplemental to the Student Insurance Plan. The GAP provides access to a 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center at 1-855-226-7915 (toll free) or collect at 1-603-952-2045. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance.

The Global Assistance Program is effective when you are outside your home country, or over 100 miles from home within the United States or when you are traveling.

The following emergency services are included*:

**Emergency Medical Evacuation and Repatriation** If you suffer an accident, injury or sickness resulting in a serious medical condition which in the opinion of the On Call physician requires transportation to be treated adequately, On Call will arrange and pay for air and/or surface transportation, medical care during transportation, communication and all usual and customary ancillary charges incurred in moving and transporting you to the nearest hospital where appropriate medical care is available.

After being treated at a medical facility, On Call will arrange and pay for the transport of the Participant with a qualified medical attendant to the Country of Domicile or Country of Residence for further medical treatment or recovery should it be deemed medically necessary by the On Call physician.

**Return of Remains** In the event of death, On Call shall make the arrangements and pay for casket or air tray, preparation and transportation of his/her remains to his/her place of residence or to the place of burial.

**Return of Dependent Children** If your Dependent(s) are present but left unattended as a result of your hospitalization or Medical Evacuation, On Call shall make and pay for travel arrangements to return them home, including a non-medical escort as needed. This service has a limit of $5,000.

**Visit by Family / Friend** If the Participant has or will be hospitalized for more than five (5) days while traveling, On Call shall make and pay for travel arrangements and suitable hotel accommodations for a person of your choice to join them. This service includes flights and up to $200 a day for hotel for a maximum of seven (7) days, up to a combined service limit of $5,000.

*On Call International must pay and arrange for all services included above, reimbursement for self-paid expenses will not be considered; it is not insurance but it is added as a service in your Student Health Insurance Policy.

**Additional Medical and Travel Assistance**

If there are third party costs associated with the following services, On Call will notify you and you will be responsible for the costs: **Pre-Trip Information, Referral** to the nearest, most appropriate medical facility, and/or provider; **Medical monitoring** by board certified emergency physicians in the United States; **Guarantee of Payment** to provider and assistance in coordinating insurance benefits; **Prescription Replacement Assistance** or Dispatch of Medicine if not available locally; **Emergency Message Forwarding** to family, friends, personal physician, school etc; **Emergency Travel Arrangements** for disrupted travel; **Legal Consultation and Referral; Interpreter Assistance and Referral; Lost Luggage Assistance; Lost/Stolen Travel Documents Assistance.**

**24 Hour Nurse Helpline**

Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. A Registered Nurse counselor will provide a clinical assessment to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Students). Nurses shall not diagnose Member’s ailments.

**Contact On Call International to access any of the GAP services described above.**

Toll Free from U.S. and Canada: 1-855-226-7915
Collect Worldwide: 1-603-952-2045

mail@oncallinternational.com

This is only an outline of services and terms, conditions and exclusions apply.