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

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

SCHEDULE OF BENEFITS (Who Pays What)

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

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

☒ the Policy Term (+ Extension of Benefits - when appropriate) ☐ Other

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

Non-Network Provider: Benefits are paid at Coinsurance 60% of the Usual and Reasonable charge.

Deductible:
Network: Individual - $0.00
Non-Network: Individual - $1,000.00

Hospital Inpatient Facility Copayment:
Network: $250.00
Non-Network: $750.00

Out-of-Pocket Expense Limit:
Network Provider: Individual - $2,000.00
Non-Network Provider: Individual - $4,000.00

Coinsurance:
Network Provider: 80% of the PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider: 60% of the Usual and Reasonable charge for Covered Medical Expenses unless otherwise stated below.

Benefit Payment for Network Providers and Non-Network Providers
This Policy provides benefits based on the type of health care provider selected. This Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

PREFERRED PROVIDER ORGANIZATION:
To locate a Cigna Provider in Your area, consult Your Provider Directory or visit www.csm.myahpcare.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION; AND**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**

BENEFITS FOR COVERED INJURY/SICKNESS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Inpatient Benefits		
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospital Room & Board Expenses	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Surgery:		
Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Inpatient Services	Same as any other Covered Sickness	
Physician's Visits while Confined: (Includes a Specialist) Visit limited to one per day of Confinement	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Preadmission Testing	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Registered Nurse Services for private duty nursing while confined	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Substance Used Disorder Inpatient Services	Same as any other Covered Sickness	
Outpatient Benefits		
Diagnostic X-ray Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Emergency Services Expenses	The PPO Allowance stated above Copayment: $100.00	The *Network* Coinsurance Amount stated above Copayment: $100.00
Home Health Care Expenses up to 28 hours per week	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospice Care Coverage	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

BENEFITS FOR COVERED INJURY/SICKNESS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Outpatient Benefits *(continued)*		
In Office Physician's Fees, including specialist, licensed registered nurse and licensed physician assistant:	100% of PPO Allowance for Covered Medical Expenses Copayment: $25.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25.00
Laboratory Procedures (Outpatient**)**	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Outpatient Services	Same as any other Covered Sickness	
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of PPO Allowance for Covered Medical Expenses Copayment: $200.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $200.00
Outpatient Prescription Drugs	100% of PPO Allowance for Covered Medical Expenses after Copayment Tier 1 Generic Copayment: $15.00 Tier 2 Preferred Brand Copayment: $30.00 Tier 3 Brand Copayment: $60.00 Tier 4 Specialty Copayment: $60.00	Not Covered
Outpatient Surgery: Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Shots and Injections unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Skilled Nursing Facility Benefit Up to 100 Days per Policy Year	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Substance Use Disorder Outpatient Services	Same as any other Covered Sickness	
Urgent Care Centers or Facilities	80% of PPO Allowance for Covered Medical Expenses Copayment: $35.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $35.00

BENEFITS FOR COVERED INJURY/SICKNESS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Other Benefits		
Accidental Injury Dental Treatment	80% of PPO Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses
Allergy Testing	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Ambulance Service	100% of PPO Allowance for Covered Medical Expenses	100% of Usual and Reasonable Charge for Covered Medical Expenses
Bariatric Surgery	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Chemotherapy and Radiation Therapy	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Chiropractic Care Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Consultant Physician Services – when requested by the attending Physician	100% of PPO Allowance for Covered Medical Expenses Copayment: $25.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25.00
Dialysis	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Durable Medical Equipment	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Infertility Treatment	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Infusion Therapy	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Pediatric Dental Care Benefits Limited to two visits in a 12 month period	100% of PPO Allowance for Preventive Services	50% of Usual and Reasonable for Preventive Services
Basic Restorative	50% of Usual and Reasonable Charge	50% of Usual and Reasonable Charge
Oral Surgery	50% of Usual and Reasonable Charge	50% of Usual and Reasonable Charge
Endodontics	50% of Usual and Reasonable Charge	50% of Usual and Reasonable Charge
Pediatric Vision Benefits Limited to 1 exam per Policy Year and 1 pair of prescribed lenses and frames or contact lenses	100% of PPO Allowance for Covered Medical Expenses for Preventive Services	50% of Usual and Reasonable Charge for Preventive Services
Physical, Occupational and Speech Therapy Subject to 20 Visits per Policy Year	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Reconstructive Surgery	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

BENEFITS FOR COVERED INJURY/SICKNESS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Other Benefits *(continued)*		
Routine Adult Eye Exam Benefit	100% of PPO Allowance for Covered Medical Expenses for Preventive Services Copayment: $25.00	70% of Usual and Reasonable Charge for Preventive Services Copayment: $25.00
Routine Newborn Care	Same as any other Covered Sickness.	
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate, intramural or club sports up to $90,000.00 per Accident	90% of PPO Allowance for Covered Medical Expenses	70% of Usual and Reasonable Charge for Covered Medical Expenses
Transplants	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mandated Benefits		
Autism Spectrum Disorders Benefit (Insured Dependent Children Under Age 19)	Same as any other Covered Sickness up to the benefit maximums described in the Benefit	
Cervical Cancer Vaccination Benefit	Same as any other Preventive Service	
Child Health Supervision Services Benefit	Same as any other Covered Sickness	
Cleft Lip and Cleft Palate Benefit	Same as any other Covered Sickness	
Clinical Trials Benefit	Same as any other Covered Sickness	
Diabetes Benefit	Same as any other Covered Sickness	
Early Intervention Services Benefit Subject to maximum 45 visits per Policy Year	This benefit is not subject to a Deductible; Same as any other Covered Sickness	
Hearing Aids for Minors Benefit	Same as any other Covered Sickness	
Hospitalization and General Anesthesia for Dental Procedures for Dependent Children Benefit	Same as any other Covered Sickness	
Inherited Enzymatic Disorders Benefit	Same as any other Covered Sickness except that Medical Foods payable on same basis as other Prescription Drugs	
Oral Anticancer Medication Benefit	Same as any other Covered Sickness	
Prosthetic Devices Benefit	Same as any other Covered Sickness	
Therapies for Congenital Defects and Birth Abnormalities Benefit (Insured Dependent Children Age 3-6)	Same as any other Covered Sickness	

INSURANCE INFORMATION SCHEDULE

POLICYHOLDER: Colorado School of Mines
Golden, CO

POLICY NUMBER: 2018A4A20

EFFECTIVE DATE: August 1, 2018

TERMINATION DATE: August 1, 2019

The Policy Year runs from the Policy Effective date until the Policy Termination Date. The Policy Term is the period of time selected by the Insured Student and for which premium has been paid that insurance is effect while an eligible student of the Policyholder.

PREMIUM SCHEDULE

CLASS OF INSURED PERSONS	Policy Term	PREMIUM RATE
Student Only	Annual 8/1/18 – 8/1/19	$2,350.00

CLASSES OF PERSONS	ENROLLMENT REQUIREMENTS	ENROLLMENT PERIOD	WAITING PERIOD
New Student	1 or more credit hours	31 Days	0 Days
Continuing Student	1 or more credit hours	31 Days	0 Days

STUDENT CLASSIFICATION

☒	Domestic	☒	International	□	Scholar	□	Other (Specify)

PARTICIPATION

□	Voluntary	☒	Waiver	□	Mandatory	□	Other (Specify)

TITLE PAGE (Cover Page)

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

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: Commercial Travelers Life Insurance Company
70 Genesee Street
Utica, NY 13502-3502
800-756-3702

STUDENT BLANKET HEALTH INSURANCE

National Guardian Life Insurance Company, referred to in this Policy as "We," "Us," "Our" or "the Company," issues this Policy to the Policyholder named in the Insurance Information Schedule to insure the students of a School.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred:
1. Due to a Covered Sickness or a Covered Injury; and
2. Sustained while the Policy is in force as hereinafter specifically provided.

We will pay the benefits under the terms of the Policy in consideration of:
1. The application for this Policy; and
2. The payment of all premiums as set forth in the Policy.

The Effective and Termination Dates for coverage under this Policy are as shown in the Schedule of Benefits and Rates. All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

The following pages form a part of this Policy as fully as if the signatures below were on each page.

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

Kimberly A. Shaul
Secretary

Mark L. Solverud
President

Non-Participating

CONTACT US

If the Insured Person has any questions about this Policy, please be sure to call Us at 800-756-3702 or the phone number on the Insured Person's ID card.

1. We do not assume any responsibility for the validity of assignment.

2. The Insured Person will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.

3. Our acknowledgment of the receipt of notice given under this Policy, or the furnishing of forms for filing proofs of loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Policy.

4. This Policy is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium or comply with any of the provisions of this Policy when such failure is due to inadvertent error or clerical mistake.

7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Policy term and within one year after the termination of this Policy.

8. Benefits are payable under this Policy only for those expenses incurred while the Policy is in effect as to the Insured Person. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits.

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SECTION I - ELIGIBILITY

Students of the Policyholder are eligible for coverage under one of the following bases. The Insurance Information Schedule will indicate who is eligible for coverage, on what basis and enrollment requirements.

1. **Waiver Participation -** All individuals shown on the Insurance Information Schedule are eligible for insurance on a Waiver Participation Basis.

3. **International Students and/or Visiting Faculty Member -** All such individuals are eligible for this plan on a Waiver Participation Basis. All eligible International Students and/or Visiting Faculty must have and maintain a current passport and a proper student Visa (either an F-1, J-1 or M-1 category Visa).

Waiver Participation Basis means that enrollment for insurance is required of all eligible persons except those who have submitted evidence of equivalent coverage satisfactory to the Policyholder.

To be eligible for coverage under this Policy, a Student must:
1. meet the enrollment requirements stated in the Insurance Information Schedule; and
2. pay the required premium; and
3. attend classes for at least the first 31 days of the period for which premium has been paid except in the case of medical withdrawal.

We maintain the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that they have not been met, our only obligation is to refund premium.

Dependent Child Coverage:

Newly Born Children - A newly born child of an Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth.

SECTION II – HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

Pre-certification means the process of determining Medical Necessity before an Insured Person receives certain Treatments, services, or supplies. The Insured Person must notify Us/the Plan Administrator and gain Our/the Administrator's approval before the Insured Person receives any Treatment, service, or supply listed in this Policy. Pre-certification is not a guarantee the Treatment, service, or supply is an Eligible Expense under the Policy. Pre-certification is not required for Emergency Services.

Pre-Certification Process
The Insured Person is responsible for notifying the claims administrator at the phone number found on the Insured Person's ID card to begin the Pre-certification process. For inpatient benefits or surgery, the call must be made at least 5 working days before Hospital Confinement or surgery.

The following inpatient benefits require Pre-certification:
1. All inpatient admissions to a Hospital, Skilled Nursing Facility, facility established primarily for the Treatment of Substance Use Disorder, or residential Treatment facility. The expected length of stay should be included in the notification;
2. All inpatient maternity care after the initial 48/96 hours;
3. Surgery.

Pre-certification is not required for:
- Medical Emergency or Urgent Care;
- Hospital Confinement for maternity care; or
- Obstetric or gynecological care when provided by a Network Provider; or
- Outpatient treatment.

Pre-certification does not guarantee that Benefits will be paid.

The Insured Person's Physician will be notified of Our decision as follows:

1. For non-urgent admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the approved number of inpatient days;
2. For confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact the claims administrator before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone;
3. For any other covered services for which We require Pre-certification, We will contact the Physician in writing or by telephone regarding Our decision.

For an urgent request, Our claims administrator will make the determination within seventy-two (72) hours after receipt of all necessary information for review. For non-urgent requests, Our claims administrator will make the determination within four (4) business days after receipt of all necessary information for review. Notice of an Adverse Determination made by Our claims administrator will be in writing and will include:

1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.
3. Notice of the availability, upon request of the Insured Person or his or her designee, of the clinical review criteria relied upon to make the Adverse Determination. The notice will specify any additional information needed by Our claims administrator to reach a decision on an appeal.

Failure by the claims administrator to make a determination within the time periods prescribed shall be deemed an Adverse Determination subject to an appeal.

The Insured Person should contact his or her Physician with questions about any Pre-certification status.

Medical Management

The benefits described in this Policy are subject to pre-certification, concurrent review, and discharge planning. The purpose of the reviews is to determine which services are Covered Medical Expenses and to assist in determining the most cost-effective methods of providing medical care. Such reviews may include analysis of procedures and the setting of where the service is performed.

Concurrent Review means review conducted during the Insured Person's stay or course of treatment in a facility, the office of a Physician, or other inpatient or outpatient health care setting.

Discharge planning means the process for determining, prior to discharge from a Hospital, the coordination and management of the care an Insured Person receives following discharge from the Hospital.

SECTION III – BENEFITS/COVERAGE (What is Covered)

Benefit Payments

Preventive Services

The following services shall be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved.
3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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

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

The following are shown in the Schedule of Benefits:
- Deductible
- Any specified benefit maximums
- Coinsurance percentages
- Copayment amounts
- 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.

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

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

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

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

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

Out-of-Pocket Expense Limit
The Out-of-Pocket Expense Limit is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. 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 Copayments will apply toward the Out-of-Pocket Expense Limit.

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.**

Benefits

1. **Accidental Injury Dental Treatment** as the result of Injury. Routine dental care and treatment are not payable under this benefit.

2. **Allergy Testing** for Insured Persons. This includes outpatient tests that the Insured Person needs such as PRIST, RAST, and scratch tests.

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

4. **Autism Spectrum Disorders Benefit** for the assessment, diagnosis, and outpatient treatment of Autism Spectrum Disorders for an Insured Person.

   Treatment for Autism Spectrum Disorders shall be for treatments that are Medically Necessary, appropriate, effective, or efficient and shall include the following:
   a. Evaluation and assessment services;
   b. Behavior training and behavior management and Applied Behavior Analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for Autism Spectrum Disorders provided by Autism Services Providers;

c. Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. For a person who is also covered the Therapies for Congenital Defects and Birth Abnormalities Benefit that follows, the level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of twenty visits for each therapy if such therapy is Medically Necessary to treat Autism Spectrum Disorders;
d. Pharmacy Care and medication on the same basis as other Prescription Drugs;
e. Psychiatric Care;
f. Psychological Care, including family counseling; and
g. Therapeutic care.

Treatment for Autism Spectrum Disorders shall be prescribed or ordered by a Physician, including a psychologist.

For purposes of this Benefit:
Applied Behavior Analysis means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

Autism Services Provider means any person who provides direct services to a person with Autism Spectrum Disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and who meets one of the following:
a. Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the Colorado medical board, and has at least one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders;
b. Has a doctoral degree in one of the behavioral or health sciences and has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders;
c. Has a master's degree or higher in behavioral sciences and is nationally certified as a "board certified behavior analyst" or certified by a similar nationally recognized organization;
d. Has a master's degree or higher in one of the behavior or health sciences, is credentialed as a related services provider, and has completed one year of direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders. Related services provider means a physical therapist, occupational therapist, or speech therapist.
e. Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a "board certified associate behavior analyst" or certified by a similar nationally recognized organization.

Autism Spectrum Disorders (ASD) includes the following neurobiological disorders: autistic disorder, asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, at the time of the diagnosis.

Pharmacy Care means medications prescribed by a Physician licensed by the Colorado medical board under Colorado law.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed by the Colorado medical board under Colorado law.

Psychological Care means direct or consultative services provided by a psychologist licensed by the state board of psychologist examiners pursuant to Colorado law.

Therapeutic Care means services provided by a speech therapist, an occupational therapist registered to practice occupational therapy pursuant to Colorado law or an Autism Services Provider. Therapeutic Care includes, but is not limited to, speech, occupational, and applied behavior analytic and physical therapies.

Treatment Plan means a plan developed for an Insured Person by an Autism Services Provider and prescribed by a Physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation for an Insured Person consisting of the Insured Person's diagnosis; proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which the Treatment Plan will be updated. The Treatment Plan shall be developed in accordance with the patient-centered medical home as defined in Colorado law.

5. **Bariatric Surgery** for Insured Persons when it is Medically Necessary.

6. **Cervical Cancer Vaccinations** for the full cost of an outpatient cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services. Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

7. **Chemotherapy and Radiation Therapy** to treat or control a serious illness, as shown in the Schedule of Benefits.

8. **Child Health Supervision Services Benefit** for Insured Persons up to the age of thirteen (13). Child Health Supervision Services rendered during a periodic review shall only be covered to the extent such services are provided during the course of one visit by or under the supervision of a single Physician, Physician's assistant, or registered nurse.

   Child Health Supervision Services means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to Colorado law to Dependent children up to age thirteen. Such services shall be provided by a Physician or pursuant to a Physician's supervision or by a primary health care provider who is a Physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a Physician.

   Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

9. **Chiropractic Care Benefit** for outpatient treatment of a Covered Injury or Covered Sickness and performed by a Physician. Coverage includes and evaluation; lab services and x-rays required for chiropractic services; and treatment of musculoskeletal disorders.

10. **Cleft Lip and Cleft Palate Benefit** for Medically Necessary care, supplies and treatment for a cleft lip or cleft palate or any condition or sickness which is related to or developed as a result of the cleft lip or cleft palate. Benefits include oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; orthodontic treatment; prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.

11. **Clinical Trials and Studies Benefit** for Routine Patient Care Costs due to an Insured Person participating in a Clinical Trial if:
    a. The Insured Person's treating Physician, who is providing covered health care services to the person under this Policy, recommends participation in the Clinical Trial after determining that participation in the Clinical Trial has the potential to provide a therapeutic health benefit to the Insured Person;
    b. The Clinical Trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding Clinical Trials, as amended;
    c. The Insured Person care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
    d. Prior to participation in a Clinical Trial or study, the Insured Person has signed a statement of consent indicating that the Insured Person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the Clinical Trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the Insured Person's health benefit plan, and all out-of-network rates will apply; and

e. The Insured Person suffers from a condition that is disabling, progressive, or life-threatening.

Benefits do not include:

a. Any portion of the Clinical Trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
b. Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
c. Extraneous expenses related to participation in the Clinical Trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participating Insured Person may incur;
d. An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
e. Costs for the management of research relating to the Clinical Trial or study; or
f. Health care services that, except for the fact that they are being provided in a Clinical Trial, are otherwise specifically excluded from coverage under this Policy.

For purposes of this Benefit:

Clinical Trial means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

Routine Patient Care Cost means all items and services that are a benefit under a health coverage plan that would be covered if the Insured Person were not involved in either the experimental or the control arms of a Clinical Trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Insured Person; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in Clinical Trials that include items or services that are typically provided absent a Clinical Trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

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

13. **Diabetes Benefit** for treatment of diabetes that shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a Physician licensed to prescribe such items pursuant to Colorado law. Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

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

15. **Dialysis** for Medically Necessary outpatient treatment of acute renal failure and end-stage renal disease.

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

17. **Early Intervention Services Benefit** for outpatient Early Intervention Services delivered by a Qualified Early Intervention Service Provider to an Eligible Child from birth through age 2 who has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for intervention services under Colorado law. Early Intervention Services specified in an eligible child's IFSP shall qualify as meeting the standard for Medically Necessary health care services as used by private health insurance plans.

    Benefits are limited to the number of visits shown in the Schedule of Benefits.

    Qualified Early Intervention Service Providers that receive reimbursement under this Benefit shall accept such reimbursement as payment in full for services provided and shall not seek additional reimbursement from either the Insured Person or Us.

    Within ninety days after the Colorado Division of Insurance determines that a child is no longer an Eligible Child for purposes of this Benefit, it shall notify Us that the child is no longer eligible and that WE are no longer required to provide the coverage.

    Early Intervention Services shall be provided as specified in the eligible child's IFSP, and such services shall not duplicate or replace treatment for Autism Spectrum Disorders which are covered under the Autism Spectrum Disorders Benefit. Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

    For purposes of this Benefit:
    Early Intervention Services means services, as defined by the Colorado Division of Insurance in accordance with Part C, that are authorized through an Eligible Child's IFSP but that exclude non-emergency medical transportation; respite care; service coordination and assistive technology unless otherwise covered as Durable Medical Equipment.

    Eligible Child means an Insured Person, from birth through two years of age, and who, as defined by the Colorado Division of Insurance, has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to Colorado law.

    Individualized Family Service Plan (IFSP) means a written plan developed pursuant to law that authorizes Early Intervention Services to an eligible child and the child's family. An IFSP shall serve as the individualized plan for an eligible child from birth through two years of age.

    Part C means the early intervention program for infants and toddlers who are eligible for services under part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq.

    Qualified Early Intervention Service Provider means a person or agency, as defined by the Colorado Division of Insurance in accordance with Part C, who provides Early Intervention Services and is listed on the registry of Early Intervention Service providers pursuant to Colorado law.

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

19. **Hearing Aids for Minors Benefit** for Medically Necessary hearing aids for Insured Persons under the age of 18 who have a hearing loss that has been verified by a Physician and by a licensed audiologist licensed. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following:
    a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
    b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;

c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

20. **Home Health Care Expense** for outpatient Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a Skilled Nursing Facility would have been necessary. Benefits are subject to the limit shown in the Schedule of Benefits.

21. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, an Insured Person requires outpatient 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.

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

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

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

23. **Hospitalization and General Anesthesia for Dental Procedures for Dependent Children**, when rendered in a Hospital, outpatient surgical facility, or other facility licensed pursuant to Colorado law, and for associated Hospital or facility charges for dental care provided to a covered Dependent child. Such Dependent child shall, in the treating dentist's opinion, satisfy one or more of the following criteria:
    a. The child has a physical, mental, or medically compromising condition; or
    b. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or
    c. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or
    d. The child has sustained extensive orofacial and dental trauma.

    Coverage is restricted to include anesthesia provided by an anesthesia provider only during procedures performed by an educationally qualified specialist in pediatric dentistry or other dentist educationally qualified in a recognized dental specialty for which Hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate Hospital training to be granted Hospital privileges. This benefit does not apply to treatment rendered for temporomandibular joint (TMJ) disorders nor does it cover the costs of the Physician or dentist.

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

25. **Hospital Room and Board Expense,** including general inpatient nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed. Benefits also include a private room rate when Medically Necessary.

26. **Infertility Treatment** is covered for the following outpatient services, including x-ray and laboratory procedures:
    a. Services for diagnosis and treatment of involuntary infertility; and
    b. Artificial insemination, except for donor semen, donor eggs and services related to their procurement and storage.

27. **Infusion Therapy** for the outpatient intravenous (into a vein) administration of nutrients, antibiotics, and other drugs and fluids when provided in the home.

28. **Inherited Enzymatic Disorders Benefit** for Medically Necessary treatment of Inherited Enzymatic Disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions. Coverage includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include Medical Foods for home use for which a Physician has issued a written, oral, or electronic prescription. There is no age limit on benefits for Inherited Enzymatic Disorders except for phenylketonuria. The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

    For purposes of this Benefit:
    Medical Foods means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or a board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enterally either via tube or oral route under the direction of a Physician. This benefit shall not be construed to apply to cystic fibrosis Insured Persons or lactose- intolerant Insured Persons or soy-intolerant Insured Persons.

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

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

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

32. **Maternity Benefit** for maternity charges as follows:
    a. Routine prenatal care.

    b. **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 cesarean 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. If the 48 hours following delivery or the 96 hours following a cesarean section falls after 8 P.M., coverage shall continue until 8 A.M. the following morning.

    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.

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

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

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

    e. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness.

33. **Mental Health Disorder Inpatient Services Benefit** for inpatient treatment of Mental Health Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

34. **Mental Health Disorder Outpatient Services Benefit** for outpatient treatment of Mental Health Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

35. **Oral Anticancer Medication Benefit** for prescribed, orally administered anticancer medication that has been approved by the federal food and drug administration and is used to kill or slow the growth of cancerous cells on the same basis as We pay for cancer chemotherapy treatment. The orally administered medication shall be provided at a cost to the Insured Person not to exceed the coinsurance percentage or the Copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. A medication provided shall be prescribed only upon a finding that it is Medically Necessary by the treating Physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the Insured Person, Physician, or other health care provider.

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

37. **Outpatient Prescription Drugs** benefits are payable for Physician-prescribed drugs for an Insured Person when drugs are obtained from an outpatient pharmacy. We will pay up to the amount shown in the Schedule of Benefits for such medication. The medication must be Medically Necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-certification.

a. Contraceptive Coverage for all Outpatient Contraceptive Services and all outpatient contraceptive drugs and devices approved by the Food and Drug Administration (FDA) for any Insured Person. For purposes of this coverage, **Outpatient Contraceptive Services** means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods, including natural family planning, to prevent an unintended pregnancy.

b. Off-Label Drug Treatments benefits are available if all of the conditions listed below are met. It is the responsibility of the prescribing Physician to submit documentation to Us that supports compliance with these conditions.
   i. The drug is approved by the FDA;
   ii. The drug is prescribed for the treatment of a life-threatening condition, including cancer, HIV or AIDS;
   iii. The drug has been recognized for treatment of that condition by one of the following:
      (a) The American Medical Association Drug Evaluations;
      (b) The American Hospital Formulary Service Drug Information.
      (c) The United State Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or
      (d) 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.

   As it pertains to this benefit, life-threatening means either or both of the following:
   (a) Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
   (b) Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

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

d. **Investigational Drugs and Medical Devices** benefits are payable for a drug or device that is investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

e. **Tobacco cessation prescription and over-the-counter (OTC) drugs** benefits are payable for tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.studentplanscenter.com or call 1-800-756-3702.

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

39. **Outpatient Surgery Miscellaneous** (excluding non-scheduled surgery) surgery performed in a Hospital emergency room, trauma center, Physician's office, outpatient or ambulatory surgical center or clinic. Benefits will be paid for services and supplies, including:
    a. Operating room;
    b. Therapeutic services;
    c. Oxygen, oxygen tent;
    d. Blood and blood plasma; and
    e. Miscellaneous supplies.

40. **Pediatric Dental Care Benefits** for covered Children up to age 19. We pay the expenses incurred for the following treatment or services. Diagnostic and Preventive procedures are limited to two outpatient dental exams in a 12 month period:
    a. Diagnostic and Preventive Procedures, as follows:
        i. Oral exams and evaluations;
        ii. Full mouth, intra-oral, and panoramic x-rays once in a 60 month period;
        iii. Bitewing x-rays once in a 12 month period;
        iv. Routine cleanings;
        v. Fluoride treatments;
        vi. Space maintainers for premature loss of deciduous (baby) posterior (back) teeth;
        vii. Sealants applied only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations; and
        viii. Palliative treatment.

        Sealant benefits do not include any repair or replacement of a sealant on any tooth within 36 months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
    b. Basic Restorative services, as follows:
        i. Analgam fillings;
        ii. Resin and composite fillings;
        iii. Crowns;
        iv. Pin Retention; and
        v. Sedative fillings.
    c. Oral Surgery, consisting of extractions.
    d. Endodontics, consisting of:
        i. Surgical periodontal services; and
        ii. Root canal therapy.

41. **Pediatric Vision Benefits** for covered Children up to age 19.
    a. One outpatient routine eye exam, including dilation if professionally indicated, each year.
    b. One pair of prescription eyeglass lenses or contact lenses each year.
    c. One eyeglass frame each year.

42. **Physical, Occupational and Speech Therapy Services** for outpatient Therapy Services.

    Therapy Services mean services administered with the expectation by the Insured Person's Physician that the therapy will result in practical improvement in the level of functioning within a two-month period of time. This coverage is limited to:
    a. 20 visits each, for Physical Therapy, Occupational Therapy, and Speech Therapy for rehabilitative services; and
    b. 20 visits each, for Physical Therapy, Occupational Therapy, and Speech Therapy for habilitative services.

    This limit does not apply to Physical, Occupation and Speech Therapy received under the Autism Spectrum Disorders Benefit.

    Occupational Therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

    Speech Therapy is limited to treatment for speech impairments due to injury or illness.

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

44. **Preadmission Testing** for routine inpatient 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.

45. **Prosthetic Devices Benefit** for Medically Necessary Prosthetic Devices that equal those benefits provided for under federal Medicare laws. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the Insured Person as determined by the Insured Person's treating Physician. Repairs and replacements of prosthetic devices are also covered unless necessitated by misuse or loss.

    For purposes of this Benefit:
    Prosthetic Device means an artificial device to replace, in whole or in part, an arm or leg.

46. **Reconstructive Surgery** is covered when a Physician determines it:
    a. Will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or
    b. Will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or
    c. Will treat congenital hemangioma (port wine stains) on the face and neck of Insured Persons 18 years and younger.

    We also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, following Medically Necessary removal of all or part of a breast.

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

48. **Routine Adult Eye Exam Benefit** covers an outpatient wellness and refraction exam to determine the need for vision correction and to provide a prescription for eyeglasses. We also cover professional exams and the fitting of Medically Necessary contact lenses when a Physician prescribes them for a specific medical condition. The contact lenses, or eyeglass lenses and frames are not covered.

49. **Routine Newborn Care -** when expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:
    a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
    b. Inpatient Physician visits for routine examinations and evaluations;
    c. Charges made by a Physician in connection with a circumcision;
    d. Routine laboratory tests;
    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.

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

51. **Skilled Nursing Care Benefit** for up to 100 days per Policy Year in a licensed Skilled Nursing Facility. Inpatient services must be Medically Necessary. Confinement for custodial care is not covered.

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

53. **Substance Use Disorder Inpatient Services Benefit** for inpatient treatment of Substance Use Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

54. **Substance Use Disorder Outpatient Services Benefit** for outpatient treatment of Substance Use Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

55. **Therapies for Congenital Defects and Birth Abnormalities Benefit** for Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for an Insured Person from the Insured Person's third birthday to the Insured Person's sixth birthday. The outpatient therapy visits shall be distributed as medically appropriate throughout the Policy Year, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

56. **Transplants** are covered on a limited basis as follows:
    a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.
    b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.

57. **Treatment for Temporomandibular Joint (TMJ) Disorders** is covered when determined to be Medically Necessary by a Physician. Outpatient services that are covered include diagnostic x-rays, lab testing, physical therapy and surgery.

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

SECTION IV – EXCLUSIONS/LIMITATIONS (What is Not Covered)

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.

This Policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of this Policy and as shown in the Schedule of Benefits.

- **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.
- preventive medicines, serums or vaccines of any kind except as covered as Preventive Service or as specifically provided under the Policy.
- dental treatment for implants, denture repair and realignment, dentures and bridges, non-medically necessary orthodontia, and periodontics, except as specifically provided in the Schedule of Benefits.
- professional services rendered by an Immediate Family Member or anyone who lives with the Insured Person.
- services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
- 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.
- any expenses in excess of Usual and Reasonable charges.

- 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 professional sport.
- 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.
- 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:
    - The date insurance terminates as to the Insured Person; and
    - 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.
- 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 accidental Injury.
- expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    - For the purposes of this provision**, Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    - For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.
- treatment to the teeth, including surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Policy definition of same. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
- an Insured Person's:
    - committing or attempting to commit a felony,
    - being engaged in an illegal occupation, or
    - participation in a riot.
- elective abortions.
- custodial care service and supplies.

Benefits are not payable for the following medications and Prescription Drugs:

- A drug which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written;
- a drug which has an over-the-counter equivalent;
- Brand-Name Prescription Drugs with generic equivalents;
- allergy sera and extracts administered via injection;
- weight control drugs;
- fertility drugs;
- vitamins, minerals, food supplements;
- sexual enhancements drugs;
- dietary supplements;
- cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, except as specifically provided in this Policy;
- blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) prescription order per Policy Year/Benefit Period;
- refills in excess of the number specified or dispensed after one (1) year of date of the prescription;

- drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- purchased after the Insured Person's coverage terminates;
- a drug that is consumed or administered at the place where it is dispensed;
- any drug that the FDA determines is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- bulk chemicals;
- non-insulin syringes, surgical supplies, durable medical equipment/medical devices with the exception of diabetic blood monitors and kits;
- stimulants;
- repackaged products;
- blood components;
- single agent opioids;
- immunology products.

Limitations on Prescription Drugs:

- **Step Therapy** when medications for the Treatment of any Covered Injury or Covered Sickness are restricted for use by a step therapy or fail-first protocol, the prescribing Physician may request an override of the restriction from Us. An override of that restriction will be granted by Us when the Physician provides all necessary information to perform the override review. The information required is listed below.
    - The prescribing Physician 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 Covered Injury or Covered Sickness; or
    - Based on sound clinical evidence or medical and scientific evidence:
        - The prescribing Physician 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 Person and known characteristics of the drug regimen; or
        - The prescribing Physician 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.
- **Specialty Prescription Drugs** may be limited access or distribution and are limited to no more than a 30-day supply.
- **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist verify that the Outpatient Prescription Drug is used correctly and safely We rely on medical guidelines, FDA-approved recommendations, and other criteria developed by Us to set these quantity limits.
- **Tier Status** – The tier status of a Prescription Drug may change. Such changes may occur without prior notice to the Insured Person. However, if the Insured Person has a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug) We will notify the Insured Person of the change. When such changes occur, the out-of-pocket expense may change. The most current tier status is available at www.csm.myahpcare.com or by calling 1-800-756-3702 the number on the Insured Person's ID card.
- **Supply Limits** – We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. The Insured Person is responsible for one (1) cost sharing amount for up to a 30-day supply.

SECTION V – MEMBER PAYMENT RESPONSIBILITY

Third Party Refund - When:

1. an Insured Person is injured through the negligent act or omission of another person (the "third party"); and
2. benefits are paid under the Policy as a result of that Injury,

We are entitled to a refund by the Insured Person of all Policy benefits paid as a result of the Injury only after the Insured Person has been fully compensated for his or her injuries.

The refund must be made to the extent that the Insured Person receives payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. The Insured Person must complete and return the required forms to Us upon request.

COORDINATION OF THIS POLICY'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.

   (1) Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.

   (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each Policy for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the Policy providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Policy providing health care benefits is separate from this plan. A Policy may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

   When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an Allowable expense, unless one of the Plans provides coverage for private Hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policy holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan . However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:

i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

However, if one spouse's/ Civil Union Partner's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

(b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

i. If a court decree states that one of the parents is responsible for the Dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
    • The Plan covering the Custodial parent;
    • The Plan covering the spouse/Civil Union Partner of the Custodial parent;
    • The Plan covering the non-custodial parent; and then
    • The Plan covering the spouse/Civil Union Partner of the non-custodial parent.

(c) For a Dependent child covered under more than one Plan of individuals who are <u>not</u> the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee,

member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If an Insured Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Our Agent or We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Our Agent or We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Our Agent or We any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Our Agent or We is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SECTION VI – CLAIMS PROCEDURE (How to File a Claim)

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

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

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

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

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

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

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

Notwithstanding, an entity that is liable as a third party for the medical costs of an Insured Person who is a medical assistance recipient or that recovers or may recover medical costs from a third party who is liable to such medical assistance recipient for medical costs is liable to the state of Colorado. Colorado is deemed to have acquired the rights as an assignee of the medical assistance recipient to any payment by a third party for medical costs.

SECTION VII - GENERAL POLICY PROVISIONS

Entire Contract. Changes: This Policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon. No agent has authority to change this Policy or waive any of its provisions.

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

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

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

SECTION VIII – TERMINATION/NONRENEWAL/CONTINUATION

Effective Dates: Insurance under this Policy will become effective on the later of:
1. The Policy effective date;
2. The beginning date of the term for which premium has been paid;
3. The day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed;
5. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be no more than 48 hours later than the departure from the Home Country.

The last date for enrollment is shown in the Insurance Information Schedule. The Enrollment Period will run from the start of the quarter or semester for which coverage is desired.

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

Reinstatement of Coverage Suspended during Periods of Active Duty: If an Insured Student is deployed by or called to active duty in the United States military and the Insured Student's coverage under the Policy terminates during the deployment or activation, We will reinstate the Insured Person when he or she returns to School as long as the Policy is still in force. Any waiting periods will be waived to the extent that coverage was in force under this Policy and such period was satisfied under the Policy before the deployment.

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

Continuous Coverage: Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under this 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 IX – APPEALS AND COMPLAINTS

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

Prospective Review means a utilization review conducted prior to an admission or course of treatment.

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

Internal Review Procedure

1. In the event of an Adverse Determination, We will notify the Insured Person immediately in writing of Our decision and the reason for the Adverse Determination. The notice will include a description of any additional information that might be necessary for reconsideration of the claim and the notice will also describe the right to appeal. The Insured Person also has the right to contact the Commissioner of Insurance or his or her office at any time. Colorado Department of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202 or 1-800-930-7455 or www.dora.state.co.us (www.dora.state.co.us%20)

2. A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. The Insured Person does not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative may:
   a. review all documents related to the claim and submit written comments and issues related to the denial; and
   b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

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

   After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 15 days for a Prospective Review request or 30 days for a Retrospective Review request after receipt of the notice requesting the first level review. These time periods may be extended one time by Us for up to 15 days, provided that We determine that an extension is necessary due to matters beyond Our control. We also have to notify the Insured Person prior to the expiration of the initial time period of the circumstances requiring the extension and the date by which We expect to make a determination. If the extension is necessary due to the Insured Person's failure to submit information necessary to reach a determination on the request, the notice of extension shall:
   a. Specifically describe the required information necessary to complete the request; and
   b. Give the Insured Person at least 30 days from the date of receipt of a notice to provide the specified information. If the deadline for submitting the specified information ends on a weekend or holiday, the deadline shall be extended to the next business day.

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

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

   In the case of an Adverse Determination involving utilization review, We will designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to determine Adverse Determination. The clinical peer(s) shall not have been involved in the initial adverse determination. We shall ensure that the individuals reviewing the Adverse Determination have appropriate expertise.

Expedited reviews of grievances involving an Adverse Determination

We shall provide expedited review of a grievance involving an Adverse Determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility. The Insured Person or the Insured Person's authorized representative shall request an expedited review orally or in writing. If the Insured Person has failed to provide sufficient information to make a determination, We shall notify the Insured Person either orally or in writing of this failure and state what specific information is needed as soon as possible, but no later than twenty-four (24) hours after receipt of the request. We shall provide a reasonable period of time to submit the necessary information, taking into account the circumstances, but no later than forty-eight (48) hours after notifying the Insured Person of the failure to submit sufficient information. We shall notify the Insured Person or, if applicable, the Insured Person's authorized representative of Our determination as soon as possible but no later than forty-eight (48) hours after the earlier of: Our receipt of the requested information; or the end of the period provided for the Insured Person to submit the requested information.

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

If the Insured Person Disagrees with Our Internal Review Determination

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

a. File a complaint with the Colorado Department of Insurance, 1560 Broadway, Suite 850, Denver, CO 80202 or 1-800-930-7455 or www.dora.state.co.us (www.dora.state.co.us%20); or
b. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

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

External Review Procedure

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 15 days for a Prospective Review request or 30 days for a Retrospective Review request plus any applicable extensions. If an Insured Person has an Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

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

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

   An external review may be requested within 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 Commissioner of Insurance, as applicable for the purpose of submitting additional information; and
      ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn't apply to expedited request or external reviews that involve an experimental or investigational treatment.
   b. If the request is not complete, We will inform the Insured Person in writing as soon as possible, but no later than 5 days following the date of the request, including what information is needed to make the request complete.
5. We will not afford the Insured Person an external review if:
   a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   b. The Insured Person has failed to exhaust Our internal review process; or
   c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

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

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

External Review of Denial of Experimental or Investigative Treatment

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

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

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

Formulary Exception Process
If a Prescription Drug is not on Our Formulary, the Insured Person, his or her designee, or the prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, the Insured Person is entitled to an external appeal as outlined in the External Appeal section. Visit Our website www.studentplanscenter.com or call the number on the Insured Person's ID card to find out more about this process.

Standard Review of a Formulary Exception
We will make a decision and notify the Insured Person, his or her designee, and the prescribing Health Care Professional no later than 72 hours after Our receipt of the Insured Person's request. If We approve the request, We will cover the Prescription Drug while the Insured Person is taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception
If the Insured Person is suffering from a health condition that may seriously jeopardize his or her health, life, ability to regain maximum function, or if the Insured Person is undergoing a current course of Treatment using a Non-Formulary Prescription Drug, he or she may request an expedited review of a Formulary exception. The request should include a statement from the prescribing Physician that harm could reasonably come to the Insured Person if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify the Insured Person, his or her designee, and the prescribing Physician no later than 24 hours after Our receipt of the request. If We approve the request, We will cover the Prescription Drug while the Insured Person suffers from the health condition that may seriously jeopardize his or her health, life or ability to regain maximum function, or for the duration of the Insured Person's current course of treatment using the Non-formulary Prescription Drug.

SECTION X – INFORMATION ON POLICY AND RATE CHANGES

Policy Year: This Policy takes effect and terminates on the corresponding dates shown in the Insurance Information Schedule. All time periods begin and end at 12:01 A.M., local time, at the address of the Policyholder.

Premium and Premium Payment: Premium for the Policy will be calculated on the basis of the rates stated in the Premium Schedule.

The Policyholder agrees to submit to Us or Our duly authorized agent the name, effective date and any other required eligibility information for each person becoming insured hereunder. This must be done within 30 days after the effective date of each Insured Person's coverage. The information, together with payment of the premium due for such persons, must be submitted.

If We or Our duly authorized agent do not receive this information within this 30 day period, coverage on any names submitted subsequent to that period will not take effect until the date We actually receive the name of the person to be insured. Coverage is also subject to payment of any premium due.

Grace Period: The Policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the coverage shall continue in force.

Refund of Premium: Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:

1. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

No other refunds will be allowed.

SECTION XI – DEFINITIONS

These are key words used in this Policy. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Policy is read.

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

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

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

Brand-Name Drug means a Prescription Drug which protected by a patent and is sold by a drug company under a specific name or trademark. The tier status is shown in the Formulary.

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

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, hyperemesis gravidarum, 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 caused by an Accident directly and independently of all other causes. Coverage under the School's policies must be inforce on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

Covered Medical Expense means those charges for any treatment, service or supplies that are:

1. Not in excess of the Usual and Reasonable charges therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance; and
3. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which:

1. causes a loss while the Policy is in force; and
2. which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

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

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, warts and moles removed for cosmetic purposes, weight reduction (other than Medically Necessary bariatric surgery), 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, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

Emergency Medical Condition means a medical condition which:

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

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

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

Formulary means a list of medications covered by the Policy. Use of medications listed the Formulary is intended 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 lists the type of drug and tier status.

Generic Prescription Drug a Prescription Drug that is identical or a bioequivalent to a Brand-Name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. A Generic Prescription Drug is not protected by a patent. The tier status is shown in the Formulary.

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

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.

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

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

Insured Person means an Insured Student or dependent of an Insured Student while insured under this Policy.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this 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 this Policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

Loss means medical expense caused by an Injury or Sickness which is covered by this Policy.

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

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

Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Non-Network Providers have not agreed to any pre-arranged fee schedules.

Off-Label Drug Treatment means a drug that is prescribed for a use different from the use for which it was approved for marketing by the Federal Food and Drug Administration (FDA).

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

Physician means a:
1. Doctor of Medicine (M.D.); or
2. Doctor of Osteopathy (D.O.); or
3. Doctor of Dentistry (D.M.D. or D.D.S.); or
4. Doctor of Chiropractic (D.C.); or
5. Doctor of Optometry (O.D.); or
6. Doctor of Podiatry (D.P.M.);

who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered.

A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician.

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

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

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

Prescription Drug means a medication that, by law, requires a prescription.

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

Skilled Nursing Facility means an institution that provides skilled nursing care under the supervision of a Physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.), and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

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

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

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

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

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

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

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

NGL Insurance Group Privacy Notice
National Guardian Life Insurance Company
Settlers Life Insurance Company

The listed companies of the NGL Insurance Group (or "NGL") are committed to protecting the privacy of the personal information we receive ("Information") about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is "your privacy is our priority."

Why We Collect and How We Use Information:

When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other NGL products or services.

Types of Information We Collect:

We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we could collect include, but are not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

We also may keep Information about your transactions with us:

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:

Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

NGL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other NGL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, NGL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

Massachusetts Policyholders: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on NGL's website, www.nglic.com.

National Guardian Life Insurance Company
Commercial Travelers Life Insurance Company

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commercial Travelers Life Insurance Company and National Guardian Life Insurance Company are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How We May Use or Disclose Your Health Information

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. **Required by Law.** As required by law, we may use and disclose your health information. We may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. **Public Health.** As required by law, we may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Health and Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. **Government Functions.** We may disclose your health information for military, national security, prisoner and government benefits purposes.

9. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation or similar laws.

10. **Disclosures to Plan Sponsors.** We may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request.

2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, we may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that we amend your health information. We are not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. We will provide one list per 12 month period free of charge; we may charge you for any additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

Our Obligations Under This Notice

We are required by law to:

1. Maintain the privacy of your health information.

2. Provide you with a notice of our legal duties and privacy practices with respect to your health information.

3. Abide by the terms of this Notice.

4. Provide you notice of a breach of any unsecured personal health information.

5. Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.

6. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

7. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law, including psychotherapy notes, personal health information for marketing purposes, and information in instances constituting the sale of personal health information.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that we maintain. Revised Notices will be distributed to you by mail.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Commercial Travelers Life Insurance Company
70 Genesee Street
Utica, NY 13502

You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

Effective Date of This Notice: June 12, 2017

NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website www.colifega.org or contact:

Colorado Life and Health
Insurance Protection Association
201 Robert S. Kerr Ave., Suite 600
Oklahoma City, OK, 73102
1 (800) 337-7796

Colorado Division of Insurance
1650 Broadway, Suite 850
Denver, CO 80202

(303) 894-7499

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

National Guardian Life Insurance Company
It's about people.

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

APPLICATION FOR STUDENT BLANKET ACCIDENT AND SICKNESS INSURANCE

1. Name of School, College or University: Colorado School of Mines

   Address: Golden, CO

2. Plan of Benefits:

   ☐ Same as current year's program, except _____

   ☐ In accordance with proposal dated _____ , 20_____

   ☒ Other In accordance with the attached Policy No. 2018A4A20.

3. Premium Rates: Student: $2,350.00 Annually

4. Terms of coverage, from: August 1, 2018 To: August 1, 2019

Any policy issued by National Guardian Life Insurance Company in consideration of this Application and payment of the first premium will include only those benefits shown in the proposal and agreed to by Us and the Applicant.

Fraud Warning: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Signature of School Official	Position or Title	Date

Agent/Broker Name: _____

Address: _____

_____

Tax I.D./Social Security Number: _____