

2018–2019 Student Health Insurance Plan

Policy No. 2018K1A28
Effective 8/1/18–8/1/19



UNIVERSITY OF SAINT JOSEPH
CONNECTICUT



University of St. Joseph

West Hartford, CT

Underwritten by:



Administered by:



2077 Roosevelt Ave
Springfield, MA 01104
1.877.657.5030

Product underwritten by
National Guardian Life Insurance Company (NGL), Madison, WI.
National Guardian Life Insurance Company is not affiliated with
The Guardian Life Insurance Company of America a.k.a. The Guardian or Guardian Life.

As Policy Form No.: NBH-280 (2014) CT et al

18-K1A28 (Cert)

PLAN COSTS

	Annual Coverage* <u>8/1/18–8/1/19</u>	Spring Semester* <u>1/1/19–8/1/19</u>
Undergraduate Student	\$2,161	\$1,257
Graduate Student	\$3,204	\$1,862

The above rates include the cost of administering the plan.

**All coverage periods begin and end at 12:01 a.m., local time, at the policyholder's address.*

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent Gallagher Student Health & Special Risk, 500 Victory Road, Quincy, MA 02171, at 1-844-288-4921.

COVERAGE

1. Accident and Sickness coverage begins on August 1, 2018, or the date of enrollment in the plan, whichever is later and ends August 1, 2019.
2. Benefits are payable during the Policy Term, subject to any Extension of Benefits.
3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.

CERTIFICATE OF STUDENT GROUP HEALTH INSURANCE

issued by

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

(Herein referred to as 'We', 'Us' or 'Our')

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2014) CT. ("the Policy").

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SECTION 1 — DEFINITIONS

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

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

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

Amino Acid Modification Preparation means a product intended for the dietary treatment of an Inherited Metabolic Disease under the direction of a Physician.

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.

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

Autism Services Provider means any person, entity or group that provides treatment for Autism Spectrum Disorder.

Autism Spectrum Disorder means a pervasive developmental disorder set forth in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Behavioral Therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, Applied Behavior Analysis, cognitive Behavioral Therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an Autism Spectrum Disorder, that are: (A) Provided to children less than fifteen (15) years of age; and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed Physician, or (iii) a licensed psychologist. For the purposes of this subdivision, Behavioral Therapy is supervised by such behavior analyst, licensed Physician or licensed psychologist when such supervision entails at least one hour of face-to-face supervision of the Autism Services Provider by such behavior analyst, licensed Physician or licensed psychologist for each ten hours of Behavioral Therapy provided by the supervised provider.

Brand Name Drugs means drugs for which the drug manufacturer's trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

Cancer Clinical Trial means an organized, systematic, scientific study of therapies, tests or other clinical interventions for purposes of treatment or palliation or therapeutic intervention for the prevention of cancer in human beings, except that a clinical trial for the prevention of cancer is

eligible for coverage only if it involves a therapeutic intervention and is a phase III clinical trial approved by one of the four entities identified in the Clinical Trial Benefit.

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

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these. Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.) Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;

5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

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

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

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

Home Health Agency means an agency or organization which meets each of the following requirements: 1. It is primarily engaged in and is federally certified as a home health agency and duly licensed, if such licensing is required, by the appropriate licensing authority, to provide nursing and other therapeutic services; 2. Its policies are established by a professional group associated with such agency or organization, including at least one Physician and at least one registered nurse, to govern the services provided; 3. It provides for full-time supervision of such services by a Physician or by a registered nurse; 4. It maintains a complete medical record on each patient; and 5. It has an administrator.

Home Health Care means services provided by a Home Health Agency in the Insured Person's home and shall consist of, but shall not be limited to, the following: 1. Part-time or intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse, if the services of a registered nurse are not available; 2. Part-time or intermittent home health aide services, consisting primarily of patient care of a medical or therapeutic nature by other than a registered or licensed practical nurse; 3. Physical, occupational or speech therapy; 4. medical supplies, drugs and medicines prescribed by a Physician, an advanced practice registered nurse or a Physician assistant and laboratory services to the extent such charges would have been covered under the policy or contract if the covered person had remained or had been confined in the hospital; and 5. Medical Social Services provided to or for the benefit of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six months or less to live.

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

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

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

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

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

Infertility means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one-year period.

Inherited Metabolic Disease means a disease for which newborn screening is required under section 19a-55 (Connecticut), as amended and for cystic fibrosis.

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

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

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

Low Protein Modified Food Product means a food product that is: 1. Specially formulated to have less than 1 gram of protein per serving; and 2. Intended to be used under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. Low protein modified food product does NOT include a natural food that is naturally low in protein.

Medical Social Services mean services rendered, under the direction of a Physician, by a qualified social worker holding a master's degree from an accredited school of social work, including but not limited to: 1. Assessment of social, psychological and family problems related to or arising out of such Insured Person's Covered Sickness or Covered Injury and treatment: 1. Appropriate action and utilization of community resources to assist in resolving such problems; and 2. Participation in the development of the overall plan of treatment of such Insured Person.

Medically Necessary or Medical Necessity means health care services that a Physician, exercising prudent clinical judgment, would provide to an Insured Person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured Person's illness, injury or disease; and
3. not primarily for the convenience of the Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Insured Person's illness, injury or disease.

Generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Mental Health Conditions means mental disorders as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. Mental Disorders include alcohol dependency and substance abuse, but do not include mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders.

Occupational Therapy means services provided by a licensed occupational therapist in accordance with a plan of care established and approved in writing by a Physician who has certified that the prescribed care and treatment are not available from sources other than the licensed occupational therapist. Such services must be provided in private practice, in a licensed Health Care Facility, or in a Partial Hospitalization program on an exchange basis. The plan must be reviewed and certified at least every two (2) months by the Physician.

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

Pain means a sensation in which a person experiences severe discomfort, distress or suffering due to provocation of sensory nerves.

Pain Management Specialist means a Physician who is credentialed by the American Academy of Pain Management or who is a board certified anesthesiologist, neurologist, oncologist or radiation oncologist with additional training in pain management.

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.

Partial Hospitalization means a formal program of care provided in a hospital or facility for periods of less than 24 hours a day.

Participation in a Riot means promotion, conspiring to promote or incite, aiding, abetting or all forms of taking part in a riot but shall not include action taken in an Insured Person's defense, if such actions of defense are not taken against persons seeking to maintain or restore law and order, including, but not limited to police officers and firefighters. Riot shall mean all forms of violence, disorder, or disturbance of the public place by 3 or more persons assembled together, whether or not acting with common intent or whether or not damage to persons or property or unlawful act of acts is the intent or the consequence of such disorder, violence or disturbance.

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, an advanced practice registered nurse, 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.

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

Rehabilitative Agency means an agency that provides an integrated multi-treatment program designed to upgrade the function of handicapped, disabled individuals by bringing together, as a team, specialized personnel from various allied health fields.

Routine Patient Care Costs with regard to Clinical Trials means: 1. Coverage for Medically Necessary health care services that are incurred as a result of the treatment being provided to the Insured Person for the purposes of the Cancer Clinical Trial that would otherwise be covered

if such services were not rendered pursuant to a Cancer Clinical Trial. Such services will include those rendered by a Physician, diagnostic or laboratory tests, hospitalization or other services provided to the Insured Person during the course of treatment in the Cancer Clinical Trial for a condition, or one of its complications, that is consistent with the usual and customary standard of care and would be covered if the Insured Person were not enrolled in a Cancer Clinical Trial; and 2. Coverage for Routine Patient Care Costs incurred for drugs provided to the Insured Person provided such drugs have been approved for sale by the federal Food and Drug Administration. Routine Patient Care Costs will NOT include: 1. The cost of an investigational new drug or device that has not been approved for market for any indication by the federal Food and Drug Administration; 2. The cost of a non-health care service than an Insured Person may be required to receive as a result of the treatment being provided for the purpose of the Cancer Clinical Trial; 3. Facility, ancillary, professional services and drug costs that are paid for by grants or funding for the Cancer Clinical Trial; 4. Costs of services that are inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis or that are performed specifically to meet the requirements of the Cancer Clinical Trial; 5. Costs that would not be covered under the Policy for non-investigational treatments including, but not limited to, items excluded from coverage under the Insured Person's coverage; and 6. Transportation, lodging, food or any other expenses associated with travel to or from a facility providing the Cancer Clinical Trial, for any Insured Person or any family member or companion.

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

Skilled Nursing/Rehabilitation Facility means a licensed institution devoted to providing medical, nursing, rehabilitation or custodial care for an Insured Person over a prolonged period, such as during the course of a chronic disease or the rehabilitation phase after an acute sickness or injury.

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

Specialized Formula means a nutritional formula for children up to age twelve (12. that is exempt from the general requirements for nutritional labeling under the statutory and regulatory guidelines of the federal Food and Drug Administration and is intended for use solely under medical supervision in the dietary management of specific diseases.

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.

Student Health Center or Student Infirmary means an on campus facility that provides: 1. Medical care and treatment to Sick or Injury students; and 2. Nursing services.

A Student Health Center or Student Infirmary does not include: 1. Medical, diagnostic and treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or 2. Inpatient care.

Total Disability or Totally Disabled, as it applies to the Extension of Benefits provision, means: 1. With respect to an Insured Person, who otherwise would be employed: (a) His or her complete inability to perform all the substantial and material duties of his or her regular occupation; with (b) care and treatment by a Physician for the Covered Injury or Covered Sickness caused the inability; 2. With respect to an Insured Person who is not otherwise employed: (a) His or her inability to engage in the normal activities of a person of like age and sex; with (b) Care and treatment by a Physician for the Covered Injury or Covered Sickness causing the inability; or (c) His or her Hospital confinement or home confinement at the direction of his or her Physician due to a Covered Injury or a Covered Sickness, except for visits to receive medical treatment.

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

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

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

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

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

SECTION 2 – ELIGIBILITY, ENROLLMENT AND TERMINATION

All Undergraduate, Physician Assistant, Pharmacy & Residential Graduate Students will be automatically enrolled in the Student Health Insurance Plan on a waiver participation basis. Insured students may enroll their eligible dependents for the same term of coverage as the Insured student on a voluntary basis.

Termination Dates: An Insured Person's insurance will terminate on the earliest of: 1. The date the Policy terminates for all insured persons; or 2. The end of the period of coverage for which premium has been paid; or 3. The date an Insured Person ceases to be eligible for the insurance;

or 4. The date an Insured Person enters military service; or 5. For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks); 6. For International Students, the date the student ceases to meet Visa requirements; 7. On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error.

Extension of Benefits: Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended as follows: 1. If an Insured Person is Hospital Confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to a minimum of 90 days from the Termination Date while such confinement continues. 2. If an Insured Person is Totally Disabled due to Covered Injury or Covered Sickness, the coverage for that condition will be extended for up to a minimum of three months from the Termination Date.

Section 3 – BENEFITS

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

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

Preventive Services: The following services shall be covered without regard to any Deductible, 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 the Usual and Reasonable Charges for Covered Medical Expenses that are incurred by the Insured Person due to a Covered Injury or Covered Sickness. Benefits payable are subject to: 1. Any specified benefit maximum amounts; 2. Any Deductible amounts; 3. Any Coinsurance amount; 4. Any Copayments; 5. The Maximum Out-of-Pocket Expense Limit.; 6. the Exclusions and Limitations provision.

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

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

See NBH-NPPO-SCHD 2017 AT THE end of this Certificate.

INPATIENT BENEFITS

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

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

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

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

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

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

If the surgical procedure is for a Medically Necessary human to human organ transplant, We will also pay benefits for Medically Necessary donor expenses and tests. We will also pay for transportation, lodging, and meal expenses for the Insured Person and one Immediate Family Member for up to \$10,000 per episode (time from initial evaluation until the sooner of discharge or cleared to return home).

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

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

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

OUTPATIENT BENEFITS

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

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

Physical Therapy - When prescribed by the attending Physician, limited to one visit per day.

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

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

Outpatient Facility Fee - We will pay an outpatient facility fee when an Insured Person is treated for a Covered Sickness or Covered Injury in an appropriately licensed outpatient facility including an ambulatory surgical center. Operating room fees for surgery are paid under the Outpatient Surgery Miscellaneous Benefit and not this benefit.

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

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

Prescription Drugs - 1. We will pay the expenses incurred for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made; 2. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met: a. The drug is approved by the FDA; b. The drug is prescribed for the treatment of a life-threatening condition; c. The drug has been recognized for treatment of that condition by one of the following: (1. The American Medical Association Drug Evaluations; (2. The American Hospital Formulary Service Drug Information; (3. The United State Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or (4. Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal. When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items a.,

b., and c. of this benefit. As it pertains to this benefit, life threatening means either or both of the following: 1. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or 2. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

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

Hospice Care Coverage - When, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

OTHER BENEFITS

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

Braces and Appliances - When prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We will also not pay for braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

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

Maternity Benefit - We will pay the expenses incurred for maternity charges as follows: 1. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. 2. Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals. **Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child. **Physician-directed Follow-up Care** including: 1. Physician assessment of the mother and newborn; 2. Parent education; 3. Assistance and training in breast or bottle feeding; 4. Assessment of the home support system; 5. Performance of any prescribed clinical tests; and 6. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals. This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "a", the home health care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness. **Routine Newborn Care** - If expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to: 1. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother; 2. Inpatient Physician visits for routine examinations and evaluations; 3. Charges made by a Physician in connection with a circumcision; 4. Routine laboratory tests; 5. Postpartum home visits prescribed for a newborn; 6. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and 7. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the treatment of such newly born child. The benefit payable for transportation will not exceed the Usual and reasonable charges up to \$200.00.

Consultant Physician Services - When requested and approved by the attending Physician.

Accidental Injury Dental Treatment for Insured Person's over age 18 - As the result of Injury. Routine dental care and treatment are not payable under this benefit.

Sickness Dental Expense Benefit for Insured Person's over age 18 - If, by reason of Sickness, an Insured Person requires treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred for the treatment.

Sleep Studies - We will pay benefits for one Medically Necessary sleep study in an Insured Person's lifetime to determine a sleep disorder. The test must be ordered by a Physician and performed in an appropriately licensed or certified facility.

Allergy Testing – We will pay benefits for allergy testing when Medically Necessary up to the limits shown in the Schedule of Benefits.

Lead Screening - We will pay benefits for an annual lead screening test for each covered Dependent child age nine to thirty-five months of age, inclusive, as required under Connecticut law.

Cardiac Rehabilitation – We will pay benefits for cardiac rehabilitation ordered and supervised by a Physician for Inured Persons recovering from heart attacks, heart surgery and percutaneous coronary intervention (PCI) procedures such as stenting and angioplasty.

Pediatric Dental Care - We will pay the Usual and Reasonable expenses incurred for the following dental care services for Insured Persons up to age 19.

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

Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

1. Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
2. Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
3. Sealants on unrestored permanent molar teeth; and
4. Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:

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

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

Prosthodontic services as follows:

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

Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not covered unless they are required:

1. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
2. For cleft palate stabilization; or
3. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

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

Procedures include but are not limited to:

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

Pediatric Vision Care - We will pay the Usual and Reasonable expenses incurred for emergency, preventive and routine vision care for Insured Persons up to age 19.

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

1. Case history;
2. External examination of the eye or internal examination of the eye;
3. Ophthalmoscopic exam;
4. Determination of refractive status;

5. Binocular distance;
6. Tonometry tests for glaucoma;
7. Gross visual fields and color vision testing; and
8. Summary findings and recommendation for corrective lenses.

Prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new frames more frequently, as evidenced by appropriate documentation.

Adult Vision Care - We will pay the Usual and Reasonable expenses incurred for an annual retina exam for an Insured Person diagnosed with glaucoma or diabetic retinopathy. We will also pay for one corneal pachymetry test in an Insured Person's lifetime.

MANDATED BENEFITS FOR CONNECTICUT

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

Accidental Ingestion or Consumption of a Controlled Drug: We will pay the Usual and Reasonable expenses incurred due to Medically Necessary inpatient and outpatient emergency medical care arising from accidental ingestion or consumption of a controlled drug, as defined by subdivision (8) of section 21a-240. We will pay the Accidental Ingestion/Consumption of Controlled Drugs Benefit shown in the Schedule of Benefits.

Ostomy Surgery Benefit. We will pay the Usual and Reasonable expenses incurred Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. Benefits are payable up to the limits shown in the Schedule of Benefits. **Ostomy** includes colostomy, ileostomy and urostomy.

Mental Health Conditions Expense Benefit: Usual and Reasonable expense incurred for treatment of a Mental Health Condition on the same that We would pay for any other Covered Sickness. In the case of benefits payable for the services of a licensed Physician or psychiatrist, benefits are also payable for the same services when rendered by the following practitioners or facilities qualified and licensed in accordance with the requirements of Chapter 38A Section 488A of the Connecticut General Laws: Psychologist, Clinical social worker, Marital and family therapist, Alcohol and drug counselor, Professional counselor, Child guidance clinic or residential treatment facility, Residential treatment facility; and Nonprofit community mental health center. **Inpatient Mental Health Conditions** - If an Insured Person requires treatment for mental and nervous disorders during Hospital Confinement, We will pay the Usual and Reasonable expense incurred on the same basis as for any other Covered Sickness. **Partial Hospitalization** - Partial Hospitalization means continuous treatment consisting of not less than four (4) hours and not more than twelve (12) hours in any 24-hour period under a program based in a Hospital or residential treatment facility. Two Partial Hospitalization days may be substituted for one inpatient day in a Hospital or related institution.

Outpatient Mental & Nervous Conditions - When the Insured Person is not Hospital confined, We will pay the Usual and Reasonable expense incurred for outpatient services on the same basis as any other Covered Sickness. This benefit is subject to the Student Health Center Referral requirements.

Autism Spectrum Disorders Benefit: We will pay the Usual and Reasonable expenses incurred for the diagnosis and treatment of Autism Spectrum Disorder on the same basis as any other Covered Sickness. We will provide coverage for the following Medically Necessary treatments, provided such treatments are identified and ordered by a Physician for an Insured Person who is diagnosed with an Autism Spectrum Disorder, in accordance with a treatment plan developed by a Physician pursuant to a comprehensive evaluation or reevaluation of the Insured Person: 1. Behavioral Therapy; 2. Prescription drugs, to the extent prescription drugs are a covered benefit for other Covered Sicknesses, prescribed by a Physician, licensed Physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of Autism Spectrum Disorder; 3. Direct psychiatric or consultative services provided by a licensed psychiatrist; 4. Direct psychological or consultative services provided by a licensed psychologist; 5. Physical therapy provided by a licensed physical therapist; 6. Speech and language pathology services provided by a licensed speech and language pathologist; and 7. Occupational therapy provided by a licensed occupational therapist. For outpatient treatment, we may review the treatment plan, in accordance with Our utilization review requirements, not more than once every six (6) months unless the Insured Person's Physician agrees that a more frequent review is necessary or changes such treatment plan.

Home Health Care Benefit: We will pay the Usual and Reasonable expenses incurred for Home Health Care provided to an Insured Person by a Home Health Care Agency as the result of a Covered Accident or Sickness. Benefits are subject to the following limitations: 1. A \$25.00 Home Health Care Deductible; 2. 100 visits in any Policy Year per Insured Person, except in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. (Each visit by a representative of a home health agency shall be considered as one Home Health Care visit; four hours of home health aide service shall be considered as one Home Health Care visit.); and 3. A \$200 benefit for Medical Social Services per Policy Year. In order for benefits to be payable, continued hospitalization would otherwise have been required if Home Health Care was not provided, except in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live. The plan covering the Home Health Care must be established and approved in writing by such Physician within seven (7) days following termination of a Hospital confinement as a resident inpatient for the same Covered Sickness or Covered Injury for which the Insured Person was hospitalized, except that in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of

six (6) months or less to live, such plan may be so established and approved at any time irrespective of whether such Insured Person was so confined or, if such Insured Person was so confined, irrespective of such seven (7) day period. Such Home Health Care must commenced within seven(7) days following discharge, except in the case of an Insured Person diagnosed by a Physician as terminally ill with a prognosis of six (6) months or less to live.

Occupational Therapy Benefit: We will pay the Usual and Reasonable expense incurred as shown in the Schedule of Benefits, for the expenses incurred for Occupational Therapy received by an Insured Person as the result of a Covered Injury or Covered Sickness. For purposes of this Benefit **Health Care Facility** means an institution that provides occupational therapy, including, but not limited to, an outpatient clinic, a Rehabilitative Agency and a skilled or intermediate nursing facility.

Diabetes Treatment Benefit: We will pay the Usual and Reasonable expenses incurred for the Medically Necessary coverage for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage will include laboratory and diagnostic tests for all types of diabetes; Medically Necessary equipment, in accordance with the Insured Person's treatment plan; and drugs and supplies prescribed by a prescribing Physician. The Outpatient Prescription Drug Expense Benefit limit does not apply.

We will also pay the expenses incurred for the outpatient self-management training for the treatment of diabetes. Such training must be prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. Such training includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training must be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of his or her license. This training benefit will cover: 1. Initial training visits, after an Insured is initially diagnosed with diabetes, that are necessary for the care and management of diabetes including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, total a maximum of ten (10) hours; 2. Training and education that is medically necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Insured Person's symptoms or condition that require modification of his or her program of self management of diabetes totaling a maximum of four hours; and 3. Training and education that is medically necessary because of the development of new techniques and treatment totaling a maximum for four (4) hours.

Treatment of Lyme Disease: We will pay the Usual and Reasonable expenses incurred for the treatment of Lyme disease. Such treatment will include: 1. Up to thirty (30) days of intravenous antibiotic therapy or sixty (60) days of oral antibiotic therapy, or both; and 2. Further treatment, if recommended by a board certified rheumatologist, infectious disease specialist or neurologist who is licensed in accordance with Connecticut statutes or who is licensed in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of Connecticut.

Hospital Dental Services Benefit: We will pay the Usual and Reasonable expenses incurred for general anesthesia, nursing and related Hospital services provided in conjunction with Inpatient, Outpatient or one day dental services if the following conditions are met: 1. The anesthesia, nursing and related Hospital services are deemed Medically Necessary by the treating dentist or oral surgeon and the Insured's Physician; and 2. The patient is either: a. determined by a licensed dentist, in conjunction with a Physician who specializes in primary care, to have a dental condition of significant dental complexity that the condition requires certain dental procedures to be performed in a Hospital; or b. a person who has a developmental disability, as determined by a Physician who specializes in primary care, that places the person at serious risk. This benefit does not cover the dental procedure.

Mastectomy, Reconstructive Breast Surgery, or Lymph Node Dissection Benefit: Benefits for such surgery will be paid under the Inpatient Surgery Benefit. Coverage will be provided for at least 48 hours of inpatient care following a mastectomy or lymph node surgery. Coverage will be provided for longer periods of inpatient care if such is recommended by the Insured Person's Physician after conferring with the Insured Person. We will also provide benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a non-diseased breast to produce a symmetrical appearance. Benefits are provided on the same basis as any other Surgical Benefit.

Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices: We will provide coverage for the surgical removal of tumors and the treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of non-dental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors. Benefits will be provided on the same basis as a Covered Sickness except that We will pay the Usual and Reasonable expense incurred in a Policy Year of up to: 1. \$500.00 for the surgical removal of tumors; 2. \$500.00 for reconstructive surgery; 3. \$500.00 for outpatient chemotherapy; 4. \$300.00 for prosthesis, except for the purposes of the surgical removal of breasts due to tumors, the annual benefit for prosthesis will be \$300.00 for each breast removed; and 5. \$1,000.00 for the surgical removal of breast implants.

Pain Management Benefit: We will pay the Usual and Reasonable expenses incurred for an Insured Person for treatment by or under the management of a Pain Management Specialist as required. We will also pay the expenses incurred for Pain treatment ordered by such specialist. Such treatment may include all means necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

Hair Prosthesis Expense Benefit: We will pay the Usual and Reasonable expenses incurred for the cost of a hair prosthesis made necessary for an Insured Person whose hair loss results from chemotherapy treatment when prescribed by a licensed oncologist.

Hypodermic Needles or Syringes Expense Benefit: We will pay the Usual and Reasonable expenses incurred when, by reason of a Covered Injury or Covered Sickness, the Insured Person is prescribed hypodermic needles or syringes by a Physician, for the purpose of administering medications for a covered condition.

Cancer Clinical Trials Expense Benefit: We will pay the Usual and Reasonable expenses incurred for the Routine Patient Care Costs associated with Cancer Clinical Trials. In order to be eligible for coverage of Routine Patient Care Costs, a Cancer Clinical Trial must be conducted under the auspices of an independent peer-reviewed protocol that has been reviewed and approved by: 1. One of the National Institutes of Health; or 2. A National Cancer Institute affiliated cooperative group; or 3. The federal Food and Drug Administration as part of an investigational new drug or device exemption; or 4. The federal Department of Defense or Veterans Affairs. We will not pay benefits for any single institution Cancer Clinical Trial conducted solely under the approval of the institutional review board of an institution or any trial that is no longer approved by one of the four entities identified above. The Insured Person seeking coverage for the Cancer Clinical Trial must provide: 1. Evidence satisfactory to Us that he or she meets all of the patient selection criteria for the Cancer Clinical Trials, including credible evidence in the form of clinical or pre-clinical data showing that the Cancer Clinical Trial is likely to have a benefit for the Insured Person that is commensurate with the risks of participation in the trial to treat the Insured Person's condition; and 2. Evidence that the appropriate informed consent has been received from the Insured Person; and 3. Copies of any medical records, protocols, test results or other clinical information used by the Physician or institution seeking to enroll the Insured Person in the clinical trial; and 4. A summary of the anticipated Routine Patient Care Costs in excess of the costs for standard treatment; and 5. Information from the Physician or institution seeking to enroll the Insured Person in the clinical trial regarding those items, including any Routine Patient Care Costs, that are eligible for reimbursement by an entity other than Us, including the entity sponsoring the clinical trial; and 6. Any additional information that may be reasonable required for the review of a request for coverage of the Cancer Clinical Trial. We will request any additional information about a Cancer Clinical Trial within five (5) business days of receiving a request for coverage from an Insured Person or a Physician seeking to enroll an Insured Person in such trial. We will NOT provide coverage for Routine Patient Care Costs that are eligible for reimbursement by another entity, including the entity sponsoring the Cancer Clinical Trial.

Infertility Benefit: We will pay the Usual and Reasonable expenses incurred for treatment of Infertility. Such treatment includes, but is not limited to the following services related to Infertility: ovulation induction, embryo transfer, intra-uterine insemination, gamete intra-fallopian transfer, in-vitro fertilization, zygote intra-fallopian transfer, uterine embryo lavage; and low tubal ovum transfer. Coverage under this benefit is limited: 1. to an Insured Student until the date of the student's 40th birthday; 2. for ovulation induction to a lifetime maximum benefit of 4 cycles; 3. for intrauterine insemination to a lifetime maximum benefit of 3 cycles; 4. for lifetime benefits to a maximum of 2 cycles, with not more than 2 embryo implantations per cycle, for IVF, gamete intra-fallopian transfer, zygote intra-fallopian or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward the maximum as 1 cycle; 5. for IVF, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer, to those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under the Policy.

Treatment of Inherited Metabolic Diseases and Medically Necessary Specialized Formulas: We will pay the Usual and Reasonable expenses incurred for Amino Acid Modified Preparations and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases if: 1. Prescribed as Medically Necessary for the therapeutic treatment of Inherited Metabolic Diseases; and 2. Administered under the direction of a Physician. We will also pay the Usual and Reasonable expenses incurred for Specialized Formulas when such Specialized Formulas are Medically Necessary for the treatment of a disease or condition and are administered under the direction of a Physician. We shall provide coverage for such preparations, food products and formulas on the same basis as outpatient prescription drugs.

Craniofacial Disorders Benefit: We will pay the Usual and Reasonable expenses incurred for the Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Insured Persons 18 years of age and younger. Such processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association, except that no benefit will be paid for Cosmetic Surgery.

Isolation Care and Emergency Services Benefit: We will pay benefits for Medically Necessary isolation care and/or emergency services that are provided by the state's mobile field hospital on the same basis as any other Covered Sickness. We will pay the same rates paid under the Medicaid program, as determined by the Connecticut Department of Social Services.

Epidermolysis Bullosa Treatment Benefit: We will pay the Usual and Reasonable expenses incurred for wound care supplies that are Medically Necessary for the treatment of Epidermolysis Bullosa that are administered under the direction of a Physician.

SECTION 4 – EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

The policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the policy.

1. **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.
2. Preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.
3. Well baby care other than as shown in the Schedule of Benefits
4. Medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.

5. Dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person's Sound, Natural Teeth or as covered in the Pediatric Dental Benefit.
6. Professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
7. Services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
8. Services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental Injury or unless otherwise covered under the Pediatric Vision Benefit.
9. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
10. 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.
11. Any expenses in excess of Usual and Reasonable charges.
12. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
13. 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.
14. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sports.
15. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
16. 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.
17. Expenses payable under any prior Policy which was in force for the person making the claim.
18. Expenses incurred during a Hospital emergency room visit which is not of an emergency nature.
19. 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.
20. Expenses incurred after:
 - o The date insurance terminates as to the Insured Person;
 - o The Maximum Benefit for each Covered Injury or Covered Sickness has been attained; and
 - o The end of the Benefit Period specified in the Benefit Schedule.
21. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
22. Charges incurred for acupuncture, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
23. Expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.
24. Expenses for radial keratotomy.
25. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
 - o For the purposes of this provision, **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
 - o For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance).
26. 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 exclusions does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits or to treatment covered under the Pediatric Dental Benefit.
27. An Insured Person's:
 - o committing or attempting to commit a felony,
 - o being engaged in an illegal occupation, or
 - o Participation in a Riot.
28. Elective abortions.
29. Congenital defects, except as provided for newborn or adopted children added after the Effective Date of coverage.
30. Custodial care service and supplies.
31. Expenses that are not recommended and approved by a Physician.
32. Conditions due to accidental bodily injury occurring prior to the Insured Person's effective date of coverage.
33. Cosmetic procedures related to Gender Dysphoria including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondoplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.

SECTION 5 – CERTIFICATE PROVISIONS

Notice of Claim: Written notice of a claim must be given to Us within 90 days after the date of Injury or commencement of Sickness covered by the Policy, or as soon thereafter as is reasonably possible. Notice given by 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 the 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.

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 the Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of the 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 the Policy which, on its Effective Date, is in conflict with the statutes of the state in which the Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

Assignment: Any portion of any benefits payable for Hospital, nursing, medical or surgical services may, at the Insured Person's option, be paid directly to such Hospital or provider of the service upon authorization by the Insured Person. We do not assume any responsibility for the validity of assignment.

SECTION 6 – COORDINATION OF BENEFITS

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

SECTION 7 - APPEALS PROCEDURE

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

External Review Procedure

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply. We shall notify the Insured Person in writing of the Insured Person's right to request an external review at the time 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 120 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, including what information is needed to make the request complete.
- 5. We will not afford the Insured Person an external review if:
 - a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
 - b. The Insured Person has failed to exhaust Our internal review process; or
 - c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

If We deny a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, We will notify the Insured Person in writing:

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

External Review of Denial of Experimental or Investigative Treatment

Within 120 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.

Agent

Gallagher Student Health & Special Risk

500 Victory Road • Quincy, MA 02171

1-844-288-4921

Website: www.gallagherstudent.com/usj

Underwritten by:

National Guardian Life Insurance Company as policy form # NBH-280 (2014) CT et al

Administered by:

Consolidated Health Plans

2077 Roosevelt Avenue • Springfield, MA 01104

1-877-657-5030 • www.chpstudent.com

For a copy of the Company's privacy notice you may:

go to www.studentplanscenter.com/privacy/nglic

or ***Request one from your school***

or ***Request one from:***

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

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

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

Representations of this plan must be approved by Us.

IMPORTANT

THIS CERTIFICATE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE AS DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE AT THE COLLEGE.

RIDER

The Policy/Certificate to which this Rider is attached is amended as follows:

1. The DEFINITIONS section is amended as described below.

The following new definition is added:

Gender Dysphoria means a conflict between an Insured Person's physical gender and the gender with which he or she identifies. The identity conflict must continue over at least 6 months and the Insured Person must meet the definition of Gender Dysphoria as described by the American Psychiatric Association.

The definition of Elective Treatment is deleted in its entirety. It is replaced with the following:

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

2. The DESCRIPTION OF BENEFITS section is amended as described below.

The following is added to the end of the Emergency Services Expenses benefit:

If Emergency Services are provided to the Insured Person by a Non-Network Provider, the provider may bill Us directly. We will reimburse the provider the greatest of the following amounts:

- a. The benefit amount We would have paid if the services had been provided by a Network provider;
- b. The Usual and Reasonable rate for such services; or
- c. The amount Medicare would reimburse for such services.

As used in this benefit, Usual and Reasonable means the eightieth percentile of all charge for the service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc. The contact information for FAIR Health, Inc. is:

FAIR Health, Inc.

530 Fifth Avenue, 18th Floor

New York, NY 10036

Phone 855-301-3247

www.fairhealth.org

The following is added to the end of the Ambulance Services benefit:

If Ambulance Service is provided to the Insured Person by a Non-Network Provider, the provider may bill Us directly. We will reimburse the provider the greatest of the following amounts:

- d. The benefit amount We would have paid if the services had been provided by a Network provider;
- e. The Usual and Reasonable rate for such services; or
- f. The amount Medicare would reimburse for such services.

As used in this benefit, Usual and Reasonable means the eightieth percentile of all charge for the service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported by FAIR Health, Inc. The contact information for FAIR Health, Inc. is:

FAIR Health, Inc.

530 Fifth Avenue, 18th Floor

New York, NY 10036

Phone 855-301-3247

www.fairhealth.org

The following benefits are added to the Other Benefits:

Hospice Care Coverage for expenses incurred when an Insured Person requires Hospice Care because of a Covered Sickness or Injury. The Insured Person must be diagnosed with a terminal illness by a licensed Physician. The medical prognosis must be death within six months. The Insured Person must elect to receive Palliative rather than curative care. We will not require any more documentation than would be 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 include palliative and supportive physical, psychological, psychosocial, and other health services to the Insured Person using a medical directed interdisciplinary team.

Palliative Care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the Insured Person as he or she experiences the stress of the dying process. Palliative care does not include treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Voluntary Sterilization Benefit for expenses incurred for voluntary sterilization procedures for males.

Gender Dysphoria Benefit for expenses incurred for the treatment of Gender Dysphoria. Benefits are subject to the limit shown in the Schedule of Benefits. Covered services include the following:

- a. Counseling by qualified mental health professional;
- b. Hormone therapy, including monitoring of such therapy;
- c. Gender reassignment surgery; and
- d. Genital reconstructive surgery.

An Insured Person who is a candidate for gender reassignment surgery for treatment of Gender Dysphoria must:

- a. Have referral letters from two qualified mental health professionals;
- b. have experienced well-documented Gender Dysphoria;
- c. have the capacity to make reasoned medical decisions;
- d. be at least 18 years of age;
- e. have addressed and controlled any significant medical or mental health concerns which may affect physical transition; and
- f. have undergone twelve months of continuous hormone therapy, unless the Insured Person has a medical contraindication or is otherwise unable or unwilling to take hormones.

An Insured Person who is a candidate for genital reconstruction surgery for treatment of Gender Dysphoria must meet the requirements listed above and must have lived for twelve months in a gender role that is congruent with the Insured Person's gender identity.

The Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices benefit is deleted in its entirety and replaced with the following:

Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices: We will provide coverage for the surgical removal of tumors and the treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of non-dental prosthesis including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, and outpatient chemotherapy following surgical procedures in connection with the treatment of tumors.

The **Hearing Aids for Children** benefit is deleted in its entirety and replaced with the following:

Hearing Aids: We will pay the Usual and Reasonable expenses incurred for the cost of hearing aids for Insured Persons. Such hearing aids will be considered durable medical equipment under the Policy.

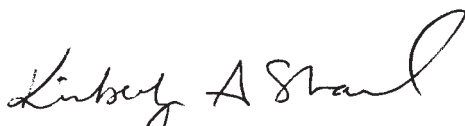
The following is added to the end of the EXCLUSIONS AND LIMITATIONS section:


- Cosmetic procedures related to Gender Dysphoria including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondoplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.

This Rider takes effect with and expires on the same date as the Policy to which it is attached.

There are no other changes to the Policy or Certificate.

In witness whereof We have caused this Rider to be signed by Our President and Secretary.


Kimberly A. Shaul, Secretary


Mark L. Solverud, President



A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

Administrative Office: Consolidated Health Plans
2077 Roosevelt • Quincy, MA 02171

ADMINISTRATIVE CHANGE ENDORSEMENT

ENDORSEMENT SCHEDULE		
Policy Owner	Attached to Policy No.	Effective Date of Coverage
University of St. Joseph's	2018K1A28	August 1, 2018

It is understood and agreed that the Policy to which this Endorsement is attached is amended as follows:

1. The NBH Update CT 2016 Rider is amended to delete the following definition in its entirety:

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

2. The NBH Update CT 2016 Rider is amended to include the following definition:

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

In every other way, the Policy remains as is.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

President

X

Policy Owner's Signature
(If required by the Company)

Countersignature of Licensed
Resident Agent, where required

PLEASE ATTACH THIS ENDORSEMENT TO YOUR POLICY.



A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

Administrative Office: Consolidated Health Plans
2077 Roosevelt • Quincy, MA 02171

ADMINISTRATIVE CHANGE ENDORSEMENT

ENDORSEMENT SCHEDULE		
Policy Owner	Attached to Policy No.	Effective Date of Coverage
University of St. Joseph's	2018K1A28	August 1, 2018

It is understood and agreed that the Policy to which this Endorsement is attached is amended as follows:

The following benefit will be included in the **Schedule of Benefits**:

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Urgent Care Centers or Facilities	80% of PPO Allowance	50% of Usual & Reasonable

The following is added to the **Description of Benefits** section, under **Outpatient Benefits**:

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

In every other way, the Policy remains as is.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

President

X _____
Policy Owner's Signature
(If required by the Company)

Countersignature of Licensed
Resident Agent, where required

PLEASE ATTACH THIS ENDORSEMENT TO YOUR POLICY.

NACE-1/15

The Policy to which this rider is attached is amended as follows:

BENEFIT PAYMENT FOR NETWORK PROVIDERS AND NON-NETWORK PROVIDERS RIDER

This Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. 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 included in this Rider.

SECTION IV – DEFINITIONS is amended by the addition of the following definitions:

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.

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

SECTION VI - DESCRIPTION OF BENEFITS is amended as follows:

The provision entitled Treatment of Covered Injury or Covered Sickness is amended to read:

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 a Covered Injury or Covered Sickness. Benefits payable are subject to:

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

The following provision is added:

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.

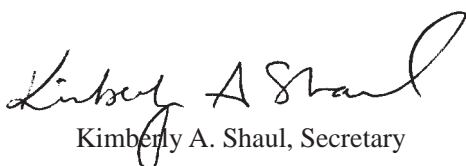
Note, however, that We will pay at the PPO Allowance level for treatment by a Non-Network Provider if:

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.

There are no other changes to the Policy.

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



Kimberly A. Shaul, Secretary



Mark L. Solverud, President

SCHEDULE OF BENEFITS

This Schedule of Benefits, issued to University of St. Joseph, replaces any other Schedule of Benefits associated with the Policy Form.

Benefit Period: When an Insured Person receives initial medical treatment within 60 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)

Preventive Services:

Network Provider: The Deductible, Coinsurance, or Copayment are not applicable to Preventive Services. Benefits for services provided by a Network Provider are paid at 100% of the PPO Allowance.

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

Deductible:

Network \$250.00 Individual

Non-Network \$500.00 Individual

Out-of-Pocket Expense Limit: Network and Non-Network Combined:

Network: \$6,350.00 Individual/\$12,700.00 Family

Coinsurance:

Network 80% of PPO Allowance (PA) of Covered Medical Expenses

Non-Network 50% of Usual & Reasonable (U&R) Medical Expenses

PREFERRED PROVIDER ORGANIZATION: To locate a Network Provider in Your area, consult Your Provider Directory or visit www.cigna.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:

1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER OR NOT THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK PROVIDER

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Inpatient Benefits		
Hospital Room & Board Expenses including: Hospital Intensive Care Unit Expense 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, Physician's visits while confined, Registered Nurse Services for private duty nursing while confined, Hospice Care for up to 6 months per Policy Year	The Network Coinsurance shown above	The Coinsurance Amount shown above
Preadmission Testing	The Network Coinsurance shown above	The Coinsurance Amount shown above
Inpatient Surgery including: Surgeon Services Anesthetist Assistant Surgeon	The Network Coinsurance shown above The Network Coinsurance shown above The Network Coinsurance shown above	The Coinsurance Amount shown above The Coinsurance Amount shown above The Coinsurance Amount shown above
Physical Therapy (inpatient)	The Network Coinsurance shown above	The Coinsurance Amount shown above
Skilled Nursing/Rehabilitation Facility Expense Benefit for up to 90 days per Policy Year	The Network Coinsurance shown above	The Coinsurance Amount shown above
Outpatient Benefits		
Outpatient Surgery including: Surgeon Services Anesthetist Assistant Surgeon 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	The Network Coinsurance shown above The Network Coinsurance shown above The Network Coinsurance shown above The Network Coinsurance shown above	The Coinsurance Amount shown above The Coinsurance Amount shown above The Coinsurance Amount shown above The Coinsurance Amount shown above
Physical Therapy/Occupational Therapy/Speech Therapy (outpatient)	\$30.00 Copayment per visit, then 100% of PPO Allowance	The Coinsurance Amount shown above
Emergency Services Expenses	\$175.00 Copayment, then 100% of PPO Allowance Copayment waived if admitted	\$175.00 Copayment, then 100% of PPO Allowance Copayment waived if admitted
In Office Physician's Fees including Chiropractic care	100% of PPO Allowance \$40.00 Copayment	The Coinsurance Amount shown above

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Outpatient Benefits (continued)		
Outpatient Facility Fee	The Network Coinsurance shown above	The Coinsurance Amount shown above
Diagnostic X-ray Services	The Network Coinsurance shown above	The Coinsurance Amount shown above
Laboratory Procedures (Outpatient)	The Network Coinsurance shown above Deductible waived	The Coinsurance Amount shown above
Prescription Drugs Prescription should be filled at a participating pharmacy	100% of PPO Allowance, subject to: \$5.00 Generic Copayment \$40.00 Preferred Brand Copayment \$40.00 Brand Copayment Deductible waived	The Coinsurance Amount shown above
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The Network Coinsurance shown above	The Coinsurance Amount shown above
Other Benefits		
Ambulance Service – Air and Ground	The lesser of: (1) billed charges, or; (2) the rate established by the Connecticut Dept. of Public Health.	The lesser of: (1) billed charges, or; (2) the rate established by the Connecticut Dept. of Public Health.
Braces and Appliances	The Network Coinsurance shown above	The Coinsurance Amount shown above
Durable Medical Equipment	The Network Coinsurance shown above	The Coinsurance Amount shown above
Maternity Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Routine Newborn Care	Same as any other Covered Sickness	Same as any other Covered Sickness
Consultant Physician Services – when requested by a physician	\$40.00 Copayment	The Coinsurance Amount shown above
Accidental Injury Dental Treatment for Insured Person's over age 18	The Network Coinsurance shown above	The Coinsurance Amount shown above
Sickness Dental Expense for Insured Person's over age 18	100% of PPO Allowance	100% of Usual & Reasonable Medical Expenses
Student Health Services/Infirmary Expense	100% of PPO Allowance, Deductible waived	
Abortion Expense	No Benefit	No Benefit
Sleep Studies One test in a lifetime	The Network Coinsurance shown above	The Coinsurance Amount shown above
Allergy Testing	The Network Coinsurance shown above	The Coinsurance Amount shown above
Lead Screening Up to the limit described in the benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Cardiac Rehabilitation	The Network Coinsurance shown above	The Coinsurance Amount shown above
Pediatric Dental Care For one dental exam every 6 months	100% PPO Allowance for Preventive Services	The Coinsurance Amount shown above for Preventive Services
Pediatric Vision Care For 1 pair of prescribed lenses and frames per Policy Year	100% PPO Allowance for Preventive Services	The Coinsurance Amount shown above for Preventive Services

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Other Benefits (continued)		
Adult Vision Care Up to the limit described in the benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Voluntary Sterilization Benefit for Males	Same as any other Covered Sickness	Same as any other Covered Sickness
Gender Dysphoria Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Hospice Care Coverage outside of Hospital or other Facility for up to 60 days per Policy Year	The PPO Allowance stated above	The Coinsurance Amount shown above
Mandated Benefits		
Accidental Ingestion/Consumption of Controlled Drugs Benefit For up to 30 days of Hospital Confinement in a Policy Year	The Network Coinsurance shown above	The Coinsurance Amount shown above
Ostomy Surgery and Supplies Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Mental Health Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Autism Spectrum Disorders Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Home Health Care Benefit – Subject to limits described in the Benefit and \$25.00 Deductible	The greater of The Network Coinsurance shown above or 75%	The greater of the Coinsurance Amount shown above or 75%
Diabetes Treatment Benefit	Same as any other Covered Sickness	The Coinsurance Amount shown above
Lyme Disease - Subject to the limits described in the Benefit	Same as any other Covered Sickness	The Coinsurance Amount shown above
Hospital Dental Services Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Mastectomy, Reconstructive Breast Surgery, or Lymph Node Dissection Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Pain Management Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Hair Prosthesis Expense Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Hypodermic Needles or Syringes Expense Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Cancer Clinical Trials Expense Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Infertility Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Treatment of Inherited Metabolic Diseases and Medically Necessary Specialized Formulas	Same as any other Outpatient Prescription Drug	Same as any other Outpatient Prescription Drug
Early Intervention Services Benefit	Same as any other Preventive Service	Same as any other Preventive Service
Hearing Aids - one hearing aid every 24 months	The Network Coinsurance shown above	The Coinsurance Amount shown above

BENEFITS FOR COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Mandated Benefits (continued)		
Craniofacial Disorders Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Neuropsychological Testing Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Isolation Care and Emergency Services Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above
Epidermolysis Bullosa Treatment Benefit	The Network Coinsurance shown above	The Coinsurance Amount shown above

CLAIMS PROCEDURE

In the event of an Injury or Sickness:

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

On Call

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

ON CALL INTERNATIONAL Global Assistance Program

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

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

The following emergency services are included*:

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

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

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

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

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

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

Additional Medical and Travel Assistance

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

24 Hour Nurse Helpline

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

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

Toll Free from U.S. and Canada: 1-855-226-7915

Collect Worldwide: 1-603-952-2045

mail@oncallinternational.com

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