2019–2020 Student Health Insurance Plan

Policy No. 2019K1A46
Effective 8/1/19–8/1/20

SAINT ANSELM COLLEGE
1889

Saint Anselm College

Manchester, NH

Serviced by:

Gallagher Student Health & Special Risk
500 Victory Road
Quincy, MA 02171
1-833-255-0741
www.gallagherstudent.com/saintanselm

Underwritten and Administered by:

NGL
It's about people.

National Guardian Life Insurance Company
Student Insurance Division
Commercial Travelers Building
70 Genesee Street • Utica, NY 13502
1-800-756-3702

As Policy Form No.: NBH-280 (2016) NH

19-K1A46 (Cert.)

Cost

Premium Cost	Annual Semester 8/1/19–8/1/20	Spring Semester 1/1/20–8/1/20
Student Only*	$2,412	$1,406

*Student rates include the cost of managing the plan.

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 Rd., Quincy, MA 02171 at 1-833-255-0741.

COVERAGE

1. Accident and Sickness coverage begins on August 1, 2019, or the date of enrollment in the plan, whichever is later and ends August 1, 2020.
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.

THIS CERTIFICATE REFLECTS THE KNOWN REQUIREMENTS FOR COMPLIANCE UNDER THE AFFORDABLE CARE ACT AS PASSED ON MARCH 23, 2010. AS ADDITIONAL GUIDANCE IS FORTHCOMING FROM THE US DEPARTMENT OF HEALTH AND HUMAN SERVICES, AND THE NEW HAMPSHIRE INSURANCE DEPARTMENT, THOSE CHANGES WILL BE INCORPORATED INTO THE CERTIFICATE.

CERTIFICATE OF
STUDENT GROUP HEALTH INSURANCE

issued by

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

PO BOX 1191, Madison, WI 53701-1191

(800) 988-0826

www.nglic.com

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

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2016) NH. ("the Policy"). This Certificate is governed by the state of New Hampshire.

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SECTION I – DEFINITIONS

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

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

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

Anesthetist means a Physician or nurse who administers anesthesia during a surgical procedure.

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.

Clean Claim means a claim for payment of a Covered Medical Expense that is submitted to Us on Our standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with Our published filing requirements.

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

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; and
2. which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Abuse Disorders.

Custodial Care means care that is primarily for the purpose of assisting an Insured Person in the activities of daily living and is not specific treatment for an illness or injury. It is care that has minimal therapeutic value and cannot in itself be expected to substantially improve a medical condition.

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

Dependent means:

1. Your Spouse;
2. Your or Your Spouse's dependent biological or adopted child or stepchild under age 26; and
3. Your or Your biological or adopted child or stepchild who has reached age 26 and who is:
   a. primarily dependent upon You for support and maintenance; and
   b. incapable of self-sustaining employment by reason of developmental disability or physical handicap.

Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Dependents are covered under this Plan if indicated on 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 Surgery does not include vasectomy.

Elective Treatment includes, treatment for acne, warts and moles removed for cosmetic purposes, pre-marital examinations and weight reduction, unless otherwise covered under the Preventive Services Benefit or the Obesity and Morbid Obesity Expense Benefit.

Elective Surgery includes, breast reduction surgery. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Electronic Claim means the transmission of data for purposes of payment of a Covered Medical Expense in an electronic data format specified by Us and, if covered by the Health Insurance Portability and Accountability Act (HIPAA), is in such form and substance as to be in compliance with such act.

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 the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Emergency Services means health care services that are provided to an Insured Person in a licensed Hospital emergency facility by a Physician after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could be expected to result in any of the following:

1. Serious jeopardy to the patient's health;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part.

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.

Habilitative Services means Medically Necessary health care services that help the Insured Person keep, learn, or improve skills and functions for daily living. Examples include therapy for a child who is not walking or talking at the expected age. Habilitative Services may include such services as physical therapy, occupational therapy, and speech therapy and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Home Country means Your country of citizenship. If You have dual citizenship, his or her Home Country is the country of the passport he or she used to enter the United States. Your Home Country is considered the Home Country for any of Your dependents while insured under the Policy.

Hospital means a public or private institution that:

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

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

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

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

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

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

International Student means an international student:
1. With a current passport and a student Visa;
2. Who is temporarily residing outside of his or her Home Country; and
3. Is actively engaged, on a full time basis, as a student or in educational research activities through the Policyholder.

In so far as the Policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

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

Medically Necessary means health care services or products provided to an Insured Person for the purpose of preventing, stabilizing, diagnosing, or treating a Sickness, Injury, or disease or the symptoms of a Sickness, Injury, or disease in a manner that is:
1. Consistent with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site, and duration;
3. Demonstrated through scientific evidence to be effective in improving health outcomes;
4. Representative of "best practices" in the medical profession; and
5. Not primarily for the convenience of the Insured Person or Physician or other health care provider.

Mental Health Disorder is a nervous or mental condition identified in the most current version of the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association, excluding those disorders designated by a "V Code" and those disorders designated as criteria sets and axes provided for further study in the DSM. This term does not include chemical dependency such as alcoholism. A mental disorder is one that manifests symptoms that are primarily mental or nervous, regardless of any underlying physical or biological cause(s) or disorder(s).

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

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

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.

Physician will also mean any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, an advanced registered nurse practitioner, a certified midwife, a Physician's assistant, social workers, clinical mental health counselor, alcohol and drug abuse counselor, marriage and family therapist, pastoral therapist, 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.

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

Skilled Nursing Facility means an institution devoted to providing medical, nursing, or custodial care for an Insured Person over a prolonged period, such as during the course of a chronic disease or the rehabilitation phase after an acute sickness or injury. The facility must be operated pursuant to law.

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

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

Substance Abuse Condition is a condition, including alcoholism or other chemical dependency, brought about when an individual uses alcohol and/or other drugs in such a manner that his or her health is impaired and/or ability to control actions is lost.

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;
   b. With 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.

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

Usual and Reasonable means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a:

1. Like service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.

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

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

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

SECTION II – ELIGIBILITY, ENROLLMENT AND TERMINATION

All domestic students will be included in the plan on a Waiver Participation Basis. All International students will be included in the plan on a Mandatory Participation Basis.

Termination Dates: An Insured Person's insurance will terminate on the earliest of:

1. The date the Policy terminates for all insured persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date an Insured Person enters military service; or
4. For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks);
5. For International Students, the date the student ceases to meet Visa requirements;
6. 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 for an Insured Person will be extended if an Insured Person is Totally Disabled due to Covered Injury or Covered Sickness on the date his or her coverage terminates under the Policy. Coverage for that condition ONLY will be extended for up 12 months from the date of Termination.

SECTION III – 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:

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; and
5. The Out-of-Pocket Expense Limit.

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. Amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Limit. However, the Insured Person's Coinsurance amounts, Deductibles and Copayment amounts will apply toward the Out-of-Pocket Expense Limit.

SCHEDULE OF BENEFITS
SILVER PLAN

Preventive Services: The Coinsurance and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of U&R.

Out-of-Pocket Expense Limit for Medical Expenses: $6,850(Individual)

The individual Out-of-Pocket Expense Limit applies to each individual Insured Person, regardless of whether this policy is for a single Insured Person or a Family.

Out-of-Pocket Expense Limit for Prescription Drugs: $2,500

Prescription Drug expenses accrue to the overall Out-of-Pocket Expense Limit.

Coinsurance: 65% of the Usual and Reasonable charge for Covered Medical Expenses unless otherwise stated below

Dependent Coverage: ☐ Yes ☒ No

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION; AND
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS.

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE/COST SHARING
Medical/Surgical Care	
1. Inpatient Services	The Coinsurance Amount shown above
In a General Hospital (Facility charges for medical, surgical and maternity admissions)	65% of Usual and Reasonable Charge for Covered Medical Expenses
In a Skilled Nursing Facility (Facility charges)	65% of Usual and Reasonable Charge for Covered Medical Expenses
In a Physical Rehabilitation Facility (Facility charges)	65% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Physician and Professional Services (Such as physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests) For Skilled Nursing or Physical Rehabilitation Facility admissions: Limited to the number of Inpatient days stated above.	65% of Usual and Reasonable Charge for Covered Medical Expenses
Registered Nurse Services for private duty nursing while confined	65% of Usual and Reasonable Charge for Covered Medical Expenses
2. Outpatient Services	
Preventive Care Immunizations for babies, children and adults (Including travel and rabies immunizations and injections considered preventive care) Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening Routine physical exams for babies, children and adults (Including one annual gynecological exam) Family planning visits Nutrition counseling Routine hearing exams (One exam each Policy Year for Members 18 years old and younger.) Pre-natal care and visits Pediatric Dental Care Pediatric Vision Care Smoking Cessation Programs Maternity care (including prenatal care, postpartum visits and screenings and breast feeding support)	Insured Person pays $0
Pediatric Dental Services (other than preventive care)	50% of Usual and Reasonable Charge for Covered Medical Expenses
Diabetes management program	Covered on the same basis as any other Covered Sickness

Medical/Surgical Care in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider, or Independent Radiology Provider (in addition to the Preventive Care above)	
Medical exams, consultations, medical treatments, telemedicine visits and Walk-In Centers	65% of Usual and Reasonable Charge for Covered Medical Expenses
Injections (including allergy injections and any injections that would not be considered a Preventive Service)	65% of Usual and Reasonable Charge for Covered Medical Expenses
Office surgery and anesthesia	65% of Usual and Reasonable Charge for Covered Medical Expenses
Surgery and anesthesia at an independent ambulatory surgical center	65% of Usual and Reasonable Charge for Covered Medical Expenses
Laboratory tests (including allergy testing)	65% of Usual and Reasonable Charge for Covered Medical Expenses
X-ray tests (including ultrasound)	65% of Usual and Reasonable Charge for Covered Medical Expenses
MRI, CT scan	65% of Usual and Reasonable Charge for Covered Medical Expenses
Chemotherapy, medical supplies and drugs	Covered on the same basis as any other Covered Sickness
Medically Necessary Abortions	Covered on the same basis as any other Covered Sickness
Outpatient Facility Care in the Outpatient Department of a Hospital, a Short Term General Hospital's Ambulatory Surgical Center, a Hemodialysis Center or Birthing Center (in addition to the Preventive Care above)	
Medical exams and consultations by a physician and telemedicine visits	65% of Usual and Reasonable Charge for Covered Medical Expenses
Operating room for surgery or delivery of a baby	65% of Usual and Reasonable Charge for Covered Medical Expenses
Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy	65% of Usual and Reasonable Charge for Covered Medical Expenses
Hemodialysis, chemotherapy, radiation therapy, infusion therapy	65% of Usual and Reasonable Charge for Covered Medical Expenses
MRI, CT Scan	65% of Usual and Reasonable Charge for Covered Medical Expenses
Facility charges, medical supplies, drugs, other ancillaries, observation	65% of Usual and Reasonable Charge for Covered Medical Expenses
Laboratory and x-ray tests (including ultrasounds)	65% of Usual and Reasonable Charge for Covered Medical Expenses
Emergency Room Visits and Urgent Care Facility Visits	
Use of the emergency room	65% of Usual and Reasonable Charge for Covered Medical Expenses
Use of a licensed hospital urgent care facility	65% of Usual and Reasonable Charge for Covered Medical Expenses
Physician's fee, surgery, MRI, CT Scan, medical supplies and drugs	65% of Usual and Reasonable Charge for Covered Medical Expenses
Laboratory and x-ray tests	65% of Usual and Reasonable Charge for Covered Medical Expenses
Ambulance Services Limited to Medically Necessary emergency transport	65% of Usual and Reasonable Charge for Covered Medical Expenses
3. Outpatient Physical Rehabilitation Services	
Physical Therapy	65% of Usual and Reasonable Charge for Covered Medical Expenses
Occupational Therapy	65% of Usual and Reasonable Charge for Covered Medical Expenses
Speech Therapy	65% of Usual and Reasonable Charge for Covered Medical Expenses

Cardiac Rehabilitation Visits	65% of Usual and Reasonable Charge for Covered Medical Expenses
Chiropractic Care	65% of Usual and Reasonable Charge for Covered Medical Expenses
Laboratory and x-ray tests furnished by a chiropractor	65% of Usual and Reasonable Charge for Covered Medical Expenses
Early Intervention Services Available from birth to a covered child's third birthday.	Covered on the same basis as any other Covered Sickness
Habilitation Services	65% of Usual and Reasonable Charge for Covered Medical Expenses
4. Home Care (in addition to the Preventative Care listed in subsection 2 above)	
Physician Services Medical exams and routine physical exams for babies, children and adults, medical treatments, telemedicine visits	65% of Usual and Reasonable Charge for Covered Medical Expenses
Injections unless considered a Preventive Service. Injections that are Preventive Services are paid under that benefit and not this benefit.	65% of Usual and Reasonable Charge for Covered Medical Expenses
Home Health Agency Services	65% of Usual and Reasonable Charge for Covered Medical Expenses
Hospice	65% of Usual and Reasonable Charge for Covered Medical Expenses
Infusion Therapy	65% of Usual and Reasonable Charge for Covered Medical Expenses
Durable Medical Equipment, Medical Supplies (including Diabetic Supplies and Enteral Formula) and Prosthetics	65% of Usual and Reasonable Charge for Covered Medical Expenses
5. Prescription Drug Benefit	100% of Usual and Reasonable Charge for Covered Medical Expenses Subject to $20 Generic Copayment Subject to $30 Preferred Brand Copayment Subject to $60 Brand Copayment Subject to $60 Specialty Drug Copayment See Prescription Card
ADDITIONAL OPTIONAL BENEFITS	
Medical Treatment Received in Home Country (International Students and/or their Dependents Only)	No Benefit

DESCRIPTION OF BENEFITS

Benefit Payments

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

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

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

We will not pay for expenses incurred that do not meet the definition of Covered Medical Expense.

Out-of-Pocket Expense Limit
The Out-of-Pocket Expense Limit for Medical treatment and Prescription Drug expenses are shown in the Schedule of Benefits. Each provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person's Coinsurance amounts, Deductibles and Copays will apply toward the Out-of-Pocket Expense Limit.

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

Payment will be made, Subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits:
1. For the Usual and Reasonable Charges for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

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.

This Section describes Covered Medical Expenses for which We provide benefits. All Covered Medical Expenses must be prescribed or furnished by a Physician. Preventive Care services are listed in subsection 2, A "Preventive Care," (below). All other Covered Medical Expenses must be Medically Necessary for the diagnosis and treatment of a Covered Injury, Covered Sickness, or for maternity care. Otherwise, no benefits are available. The Covered Medical Expenses described in this Section are available for treatment of the diseases and ailments caused by obesity and morbid obesity, as required by New Hampshire law.

1. Inpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Inpatient medical/surgical admissions. This includes maternity admissions. Coverage includes the following:

A. Care in a Hospital - semi-private room and board, nursing care, pharmacy services and supplies, laboratory and x-ray tests, operating room charges, delivery room and nursery charges, physical, occupational and speech therapy typically provided in a Hospital while an Insured Person is a bed patient (Inpatient). Custodial Care is not covered.
   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. 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.
   2. Inpatient Physician charges or surgeon charges will be covered the same as for any other Covered Sickness for both mother and newborn child.

B. Care in a Skilled Nursing Facility or Physical Rehabilitation Facility - semi-private room and board, nursing and ancillary services typically provided in a Skilled Nursing or Physical Rehabilitation Facility while an Insured Person is a bed patient (Inpatient). Benefits may be limited as shown in the Schedule of Benefits. When counting the number of Inpatient days, the day of admission is counted but the day of discharge is not. Custodial Care is not covered.

C. Inpatient Physician and Professional Services - Physician visits, consultations, surgery, anesthesia, delivery of a baby, therapy, laboratory and x-ray tests. Benefits for Inpatient medical care are limited to daily care furnished by the attending Physician, unless another Physician's services are Medically Necessary. For Skilled Nursing or Physical Rehabilitation Facility admissions, *benefits may be limited, as shown on* the Schedule of Benefits. Custodial Care is not covered.

Please see subsection 6, "Important Information about Other Covered Medical Expenses" for related information about Inpatient services. Also, see Section IV for important "Limitations and Exclusions" that may apply to Inpatient Services.

2. Outpatient Services

Benefits are available for Medically Necessary facility and professional fees related to Outpatient medical/surgical care. Coverage includes the following:

A. Preventive Care. In general, the term "Preventive Care" under the Policy refers to medical care for adults and children with no current symptoms of a medical condition associated with the care. For Insured Persons who are undergoing active treatment for a current diagnosis is not considered Preventive Care. Some exceptions to this definition are listed in this subsection but otherwise, services for the diagnosis or treatment of an illness, injury or medical condition are covered under other applicable sections of the Policy. Whether or not a service is Preventive Care, Covered Medical Expenses are subject to the cost sharing requirements specified on the Schedule of Benefits. For the purposes of this subsection, Preventive Care services are:

1. Immunizations for babies, children and adults (including travel and rabies immunizations and injections considered preventive care);
2. Mammograms, pap smears, lead screening, prostatic specific antigen (PSA) screening;
3. Routine physical exams for babies, children and adults (including one annual gynecological exam);
4. Family planning visits, such as medical exams related to family planning and genetic counseling.
   a. Outpatient/office contraceptive services are covered, provided that the services are related to the use of FDA approved contraceptives. Examples of covered contraceptive services are: office visits, consultations, examinations and services related to the use of federal legend oral contraception or IUD insertion, diaphragm fitting, vasectomy or contraceptive injections.
   b. Please note that prescription and nonprescription contraceptive drugs and devices (such as oral contraceptives, IUDs, diaphragms, and contraceptive injections) are not covered under this benefit. See item Essential Health Benefits section 5 Prescription Drugs below.
   c. Please see subsection 6, C for information about "Infertility Diagnostic Services";
5. Nutrition counseling as part of a Physician practice or an Outpatient hospital clinic. *Benefits may be limited as shown on the Schedule of Benefits.*
   a. Benefits are available for weight management counseling provided during covered nutrition counseling visits or as part of a covered diabetes management program (see 7, "diabetes management programs" below). Benefits are also available for Medically Necessary Covered Medical Expenses furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.
   b. For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see subsection 6, G, 4, "Surgery for conditions caused by obesity."
6. Routine hearing exams to determine the need for hearing correction. *Benefits may be limited, as shown on The Schedule of Benefits.* Please see subsection 6, B, "Hearing Services" for information about services for ear disease or injury.
7. Diabetes Management Programs. Covered Medical Expenses must be ordered by a Physician and furnished by a qualified diabetes education Physician. Covered Medical Expenses include:
   a. Individual counseling visits;
   b. Group education programs and fees required to enroll in an approved group education program; and
   c. External insulin pump education. Please see subsection 4 E, "Durable Medical Equipment, Medical Supplies and Prosthetics" for information about coverage for external insulin pumps.
8. Smoking Cessation Programs when recommended by a Physician and while under a Physician's care.
9. Maternity care (including prenatal care, postpartum visits and screenings and breast feeding support).

   In addition to the limitations and exclusions listed in Section IV of the Policy, the following limitations apply specifically to diabetes management services:

   Benefits are available for weight management counseling provided as part of a covered diabetes management program or during covered nutrition counseling visits (see 5 above). Benefits are also available for Medically Necessary Covered Medical Expenses furnished to treat diseases and ailments caused by or resulting from obesity or morbid obesity.

   For information about surgical services to treat diseases and ailments caused by or resulting from obesity or morbid obesity, please see subsection 6, G, 4, "Surgery for conditions caused by obesity."

B. Medical/Surgical Care furnished in a Physician's Office or Walk-In Center or furnished by an Independent Ambulatory Surgical Center, Independent Infusion Therapy Provider, Independent Laboratory Provider or Independent Radiology Provider (in addition to the Preventive Care above). In addition to Preventive Care commonly provided in a Physician's office (see A, above), the following services are covered:

1. Medical exams, consultations, surgery and anesthesia, injections (including allergy injections), medical treatments (including allergy treatments and radiation treatments);
2. Laboratory and x-ray tests (including allergy testing and ultrasound);
3. CT Scan, MRI, chemotherapy, infusion therapy;
4. Medical supplies and drugs administered during the visit. Benefits are available for covered prescription medications, injectable drugs, radioactive materials, dressings and casts administered or applied during a medical care visit for the prevention of disease, illness or injury or for therapeutic purposes. No benefits are available for fertility hormones or fertility drugs. (Hormones, insulin and prescription drugs are not covered under any portion of the Policy when purchased in an Outpatient setting for use outside the setting. Please see subsection 4, E "Durable Medical Equipment, Medical Supplies and Prosthetics" for coverage information.);
5. Maternity care. *Total maternity care includes the Physician's fees for delivery, Inpatient medical care, prenatal care and postpartum visits.* Most often, an Insured Person's Physician bills all of these fees together in one charge for delivery of a baby and the Benefit includes all of

the services combined. The Benefit is available according to the coverage in effect on the date of delivery. Note: If a Physician furnishes *only* prenatal care or the delivery, or postpartum care, benefits are available according to the coverage in effect on the date an Insured Person receives the care.

Benefits are available for *routine* maternity care furnished by a New Hampshire Certified Midwife (NHCM), provided that he or she is certified under New Hampshire law and acting within an NHCM's scope of practice as defined in New Hampshire law. Coverage includes, but is not limited to home deliveries.

Benefits are available for urgent and emergency care as described in Section III and all of the Medically Necessary Covered Medical Expenses described in this Section with respect to pregnancy, tests and surgery related to pregnancy, complications of pregnancy, termination of pregnancy or miscarriage. Ultrasounds in pregnancy are covered only when Medically Necessary. Please see subsection 6 "Important Information About Other Covered Medical Expenses," C, "Infertility Diagnostic Services" for important restrictions regarding infertility treatment.

6. Coverage for Outpatient Contraceptive Services: We will pay the Usual and Reasonable expenses incurred for Outpatient Contraceptive Services under the same terms and conditions as for other Outpatient services. We shall also cover all prescription contraceptive drugs and prescription contraceptive devices approved by the U.S. Food and Drug Administration.

   For purposes of this benefit:

   Outpatient Contraceptive Services means consultations, examinations, and medical services, provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy which has been approved by the U.S. Food and Drug Administration.
7. Coverage for Medically Necessary Abortions: We will pay the Usual and Reasonable expenses incurred for abortions when determined to be Medically Necessary.

C. Outpatient Facility Care: in the Outpatient Department of a Hospital, a Hospital's Ambulatory Surgical Center, Hemodialysis Center or Birthing Center. In addition to Preventive Care commonly provided in an Outpatient facility (see A, above), benefits are available for Medically Necessary facility and professional services in the Outpatient department of a Hospital, Ambulatory Surgical Center, Hemodialysis Center or Birthing Center. Coverage includes the following:
   1. Medical exams and consultations by a Physician;
   2. Operating room for surgery or delivery of a baby;
   3. Physician and professional services: surgery, anesthesia, delivery of a baby or management of therapy;
   4. Hemodialysis, chemotherapy, radiation therapy, infusion therapy;
   5. CT Scan, MRI;
   6. Medical supplies, drugs, other ancillaries, facility charges, including but not limited to facility charges for observation. Observation is a period of up to 24 hours during which An Insured Person's condition is monitored to determine if Inpatient care is Medically Necessary; and
   7. Laboratory and x-ray tests (including ultrasounds).

Also, see subsection 3, "Outpatient Physical Rehabilitation Services".

D. Emergency Room Visits for Emergency Care. Covered Medical Expenses are shown on An Insured Person's Schedule of Benefits. Please see Section III for important guidelines about "Urgent and Emergency Care."

E. Ambulance Services. Benefits are available for Medically Necessary ambulance transport to a medical facility for Emergency Care. For example, coverage includes ambulance transport to a hospital from the scene of an accident or to a Hospital from an Insured Person's home due to symptoms of a heart attack.

   In addition to the limitations and Exclusions listed in Section IV "Limitations and Exclusions," the following limitations apply to Ambulance Services:
   1. Nonemergency ambulance transport is not covered. If transport in a non-emergency vehicle (such as by car) is medically appropriate, ambulance transport is not covered. No benefits are available for the cost of transport in vehicles such as chair ambulance, car or taxi;
   2. No benefits are provided for ambulance transportation to or from medical appointments. No benefits are provided for non-ambulance transportation to or from medical appointments; and
   3. Benefits are provided for air ambulance transport furnished by an air ambulance service to take an Insured Person to a Hospital only when it is Medically Necessary for such person to be transported by air rather than ground ambulance.

F. Telemedicine Services. Telemedicine is the delivery of Covered Medical Expenses by a Physician to an Insured Person by means of audio, video or other electronic media for the purposes of diagnosis, consultation or treatment without in-person (face to face) contact between the Physician and Insured Person. Telemedicine does not include the use of audio-only telephone or facsimile.

   Benefits are available for telemedicine service provided that all of the following conditions are met:
   1. The services would be covered if they were delivered during an in-person consultation instead of by telemedicine; and
   2. The services must be Medically Necessary.

   Except as stated above, no benefits are available for telemedicine services.

   Cost sharing amounts for covered telemedicine services are the same as for similar services as shown on the Schedule of Benefits.

   The maximum benefit for telemedicine services includes the Physician's professional services and costs associated with operating the Physician's practice. Unless additional benefits would be available if services were delivered during an in-person consultation instead of by telemedicine, no additional benefits are available for costs such as a Physician's or Insured Person's telephone and/or facsimile or e-mail transmissions, technology hardware or software costs, office, facility or home operating costs or other site location costs, fees for use of a facility or costs for equipment or for the services of vendors, including electronic/internet service Physician costs.

3. Outpatient Physical Rehabilitation and Habilitative Services

Benefits are available for Medically Necessary Outpatient Physical Rehabilitation Services. Coverage includes the following:

A. Physical Therapy, Occupational Therapy and Speech Therapy in an office or in the Outpatient department of a Hospital or Skilled Nursing Facility. *Benefits may be limited, as shown on the Schedule of Benefits.* Physical therapy must be furnished by a licensed physical therapist.

Occupational therapy must be furnished by a licensed occupational therapist. Speech therapy must be furnished by a licensed speech therapist. Otherwise, no benefits are available. Speech therapy services must be Medically Necessary to treat speech and language deficits or swallowing dysfunctions. Coverage for speech therapy is limited to the following speech therapy services:

1. An evaluation by a licensed speech therapist to determine if speech therapy is Medically Necessary; and
2. Individual speech therapy sessions (including services related to swallowing dysfunctions) by a licensed speech therapist.

Services must provide significant improvement within a reasonable and generally predictable period of time. Services must require the direct intervention, skilled knowledge and attendance of a licensed physical, occupational or speech therapist. No benefits are available for on-going or life-long exercise and education programs intended to maintain fitness, including voice fitness, or to reinforce lifestyle changes, including lifestyle changes affecting the voice. Such on-going services are not covered, even if ordered by an Insured Person's Physician or supervised by skilled program personnel. In addition to the "Limitations and Exclusions" listed in Section IV, no benefits are available for voice therapy, vocal retraining, preventive therapy or therapy provided in a group setting. No benefits are available for educational reasons or for Developmental Disabilities, except as stated in D, "Early Intervention Services," below. No benefits are available for recreational or occupational reasons. Physical therapy for TMJ disorders is not covered.

B. Cardiac Rehabilitation. Benefits are available for Outpatient cardiac rehabilitation programs. Covered Medical Expenses are: exercise and education under the direct supervision of skilled program personnel in the intensive rehabilitation phase of the program. The program must start within three months after a cardiac condition is diagnosed or a cardiac procedure is completed. The program must be completed within six months of the cardiac diagnosis or procedure.

No benefits are available for portions of a cardiac rehabilitation program extending beyond the intensive rehabilitation phase. On-going or life-long exercise and education maintenance programs intended to maintain fitness or to reinforce permanent lifestyle changes are not covered, even if ordered by an Insured Person's Physician or supervised by skilled program personnel.

C. Chiropractic Care. *Benefits may be limited as shown on the Schedule of Benefit.* The following are Covered Medical Expenses:

1. Office visits for assessment, evaluation, spinal adjustment, manipulation and physiological therapy before (or in conjunction with) spinal adjustment; and
2. Medically Necessary diagnostic laboratory and x-ray tests.

In addition to the "Limitations and Exclusions" stated in Section IV, the following limitations apply specifically to chiropractic care:

1. Wellness care is not covered;
2. The services must be Medically Necessary for the treatment of an illness or injury that is diagnosed or suspected by a Physician; and
3. Chiropractic care must be provided in accordance with New Hampshire law.

An Insured Person may choose to receive non-Covered Medical Expenses. However, an Insured Person is responsible for the full cost of any chiropractic care that is not covered, as stated in this subsection.

D. Early Intervention Services. Early intervention services are covered for eligible Insured Persons from birth to the Insured Person's third birthday. Eligible Insured Persons are those with an identified Developmental Disability or delay. Covered Medical Expenses include Medically Necessary physical, speech/language and occupational therapy, nursing care, and psychological counseling provided by Physicians, including Clinical Social Workers. Physical, speech and occupational therapy visits do not count toward any annual limits that may apply to A, (above). *However, benefits may be limited, as shown on the Schedule of Benefits.*

E. Habilitation Services. Benefits are available for Outpatient Habilitative Services that are Medically Necessary and ordered by a Physician.

4. Home Care.

Benefits are available for Medically Necessary Home Care. Covered Medical Expenses are limited to the following:

a. Physician Services - Physician visits to An Insured Person's home or place of residence to furnish medical care that is the same as or similar to services ordinarily provided in an office setting.

b. Home Health Agency Services. Benefits are available for Medically Necessary services furnished by an appropriately licensed Home Health Agency in an Insured Person's home or other place of residence. Benefits *may be limited as shown on the Schedule of Benefits.*

Benefits are available only when, due to the severity of a medical condition, it is not reasonably possible for an Insured person to travel from his or her home to another treatment site.

Covered Medical Expenses are limited to the following:

1. Part-time or intermittent skilled nursing care by, or under the supervision of a Registered Nurse,
2. Part-time or intermittent home health aide services that consist primarily of caring for the Insured Person under the supervision of a Registered Nurse,
3. Prenatal and postpartum homemaker visits. Homemaker visits must be Medically Necessary. Otherwise, no benefits are available. For example, if an Insured Person is confined to bed rest or his or her activities of daily living are otherwise restricted by order of his or her Physician, prenatal and/or postpartum homemaker visits may be considered Medically Necessary.
4. Physical, occupational, and speech therapy. Therapy provided by a Home Health Agency does not count toward annual limits that may apply to Section 3, A (above).
5. Non-prescription medical supplies and drugs. Non-prescription medical supplies and drugs may include surgical dressings and saline solutions. Prescription drugs, certain intravenous solutions and insulin are not included.

c. Hospice. Hospice care is home management of a terminal illness. Benefits are available for Covered Services, provided that the following conditions are met:

1. Care must be Medically Necessary;
2. The Insured Person must have a terminal illness with a life expectancy of six months or less, as certified by a Physician;

3. The Insured Person or his/her legal guardian must make an informed decision to focus treatment on comfort measures when treatment to cure the condition is no longer possible or desired;
4. The Insured Person or his/her legal guardian, the Insured Person's Physician and medical team must support hospice care because it is in the Insured Person's best interest, and
5. A primary care giver must be available on an around-the-clock basis. A primary care giver is a family member, friend or hired help who accepts 24-hour responsibility for the patient's care. The primary care giver does not need to live in the patient's home.

The hospice Physician will establish an individual hospice plan that meets an Insured Person's individual needs. Each portion of a hospice plan must be Medically Necessary. Otherwise, no benefits are available. Covered Medical Expenses that may be part of the individual hospice plan are:

1. Skilled nursing visits,
2. Home health aide and homemaker services,
3. Physical therapy for comfort measures. These therapy services do not count toward annual visit limits that may apply to 3, A, "Physical Therapy, Occupational Therapy and Speech Therapy" (above),
4. Social service visits,
5. Durable medical equipment and medical supplies. These items do not count toward any annual dollar maximum stated on page 1 of the Schedule of Benefits for "Medical Equipment, Medical Supplies and Prosthetics."
6. Respite care (in the home) to temporarily relieve the primary care giver from care-giving functions,
7. Continuous care, which is additional respite care to support the family during the patient's final days of life,
8. Bereavement services provided to the family or primary care giver following the death of the hospice patient.

D. Infusion Therapy. Benefits are available for Medically Necessary home infusion therapy furnished by a licensed infusion therapy Physician. Covered Medical Expenses are:
   1. Home nursing services for intravenous antibiotic therapy, chemotherapy or parenteral nutrition therapy,
   2. Antibiotics, chemotherapy agents, medications and solutions used for parenteral nutrients,
   3. Associated supplies and portable, stationary or implantable infusion pumps.

E. Durable Medical Equipment, Medical Supplies and Prosthetics. Benefits are available for durable medical equipment (DME), medical supplies and prosthetic devices. Services covered under this subsection are subject to Deductible and /or Coinsurance for Durable Medical Equipment, Medical Supplies and Prosthetics as shown on the Schedule of Benefits. These are separate cost sharing amounts that do not count toward meeting any other Deductible or Coinsurance requirement under the Policy. Exceptions are stated below in this subsection.
   1. Durable medical equipment (DME). Benefits are available for covered DME. In order to be Covered, the DME must meet all of the following criteria. Otherwise, no benefits are available. The DME must be:
      a. Primarily and customarily used for a medical purpose;
      b. Useful only for the specific illness or injury that an Insured Person's Physician has diagnosed or suspects;
      c. Non-disposable and specifically designed and intended to withstand repeated use; and
      d. Appropriate for use in the home.

   Examples of covered DME include, but are not limited to: crutches, apnea monitors, oxygen and oxygen equipment, wheelchairs, special hospital type beds or home dialysis equipment. Enteral pumps and related equipment are covered for Insured Persons who are not capable of ingesting enteral formula orally. Oxygen humidifiers are covered if prescribed for use in conjunction with other covered oxygen equipment.

   Benefits are available for Medically Necessary external insulin infusion pumps for insulin dependent diabetics. Benefits are subject to all of the terms and conditions of the Policy including Copayment, Deductible, and Coinsurance, requirements and the limitations, and other party liability rules. Please see subsection 2 "Outpatient Services," A "Preventive Care" (above in this Section) for information about external insulin pump education. Implantable insulin infusion pumps are not covered.

   Benefits are available for orthopedic braces for support of a weak portion of the body or to restrict movement in a diseased or injured part of the body.

   We cover a hearing aid for each ear, as Medically Necessary, in addition to related services necessary to assess, select and fit the hearing aid once every 60 months. Benefits are also available for one hearing aid per ear each time a hearing aid prescription changes for Insured Persons.
   2. Medical Supplies. Benefits are available for medical supplies. In order to be covered, medical supplies must be small, disposable items designed and intended specifically for medical purposes and appropriate for treatment of the Covered Sickness or Covered Injury that an Insured Person's Physician has diagnosed. Otherwise, no benefits are available. Examples of covered medical supplies include: needles and syringes, ostomy bags and skin bond necessary for colostomy care. Eyewear (frames and/or lenses or contact lenses) is covered only if the lens of an Insured Person's eye has been surgically removed or is congenitally absent. Other covered medical supplies are:
      a. Diabetic supplies. Diabetic supplies are covered for Insured Persons who have diabetes. Examples of covered diabetic supplies include, but are not limited to: diabetic needles and syringes, blood glucose monitors, test strips and lancets. Coverage is provided under this subsection when diabetic supplies are purchased from a licensed durable medical equipment Physician or from a durable medical equipment supplier who is accredited by CMS and/or licensed by the state of New Hampshire.
      b. Enteral formula and modified low protein food products. Benefits are available for enteral formulas required for the treatment of impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length or motility of the gastrointestinal tract. Benefits are available for food products modified to be low protein for persons with inherited diseases of amino acids and organic acids. An Insured Person's Physician must issue a written order stating that the enteral formula and/or food product is needed to sustain life, is Medically Necessary; and is the least restrictive and most cost-effective means for meeting An Insured Person's medical needs. Otherwise, no benefits are available. Except as provided in this subsection or as required by law, no benefits are available for nutrition and/or dietary supplements.

         Any Deductible, Coinsurance and Maximum Benefit stated on the Schedule of Benefits specifically for Durable Medical Equipment, Supplies and Prosthetics do not apply to enteral formula and modified low protein food products. If You purchase enteral formula or food products modified to be low protein in an Outpatient setting, benefits are subject to the cost sharing amounts shown on the Schedule of Benefits "Outpatient Services" for "medical supplies".

3. Prosthetic Devices. Benefits are available for prosthetic devices that replace an absent body part or the function of a permanently impaired body part. Prosthetic limbs are covered. Prosthetic limbs are artificial devices that replace, in part or in whole, an arm or leg. Post-mastectomy breast prostheses and scalp hair prosthesis are other examples of covered prosthetic devices.

   Coverage for external breast prostheses is limited to 2 prostheses per breast, per Policy Year. The maximum benefit for breast prosthesis includes the cost of fitting for the prosthesis.

   Clothing necessary to wear a covered prosthetic device is also covered. This includes stump socks worn with prosthetic limbs and post-mastectomy bras worn with breast prosthesis. Coverage for post- mastectomy bras is limited to 3 bras per Insured Person, per Policy Year.

   Scalp hair prosthesis is an artificial substitute for scalp hair that is made specifically for the Insured Person. Benefits are available for scalp hair prostheses for Insured Persons who have hair loss as a result of alopecia areata, alopecia totalis, or alopecia medicamentosa resulting from treatment of any form of cancer or leukemia and/or who have permanent hair loss as a result of a Covered Injury.

   An Insured Person pays no Copayment, Deductible or Coinsurance for covered scalp hair prostheses. Any Deductible, Coinsurance and/or Maximum Benefit in the Schedule of Benefits for Medical Equipment, Medical Supplies and Prosthetics does not apply to scalp hair prostheses.

   To be eligible for benefits for scalp hair prostheses, an Insured Person's Physician must state in writing that the prosthesis is Medically Necessary. He or she must submit the Physician's statement with his or her claim.

   Except as described above, no benefits are available for scalp hair prostheses or wigs. For example, except as stated above, no benefits are available for temporary hair loss. No benefits are available for male pattern baldness.

4. Limitations. In addition to the "Limitations and Exclusions" listed in Section IV, the following limitations apply specifically to this subsection:
   a. Whether an item is purchased or rented, benefits are limited to the least expensive service that meets an Insured Person's medical needs. If an Insured Person's service is more costly than is Medically Necessary, he or she will be responsible for paying the difference between the benefit payable for the least expensive service and the charge for the more expensive service. If an Insured Person rents or purchases equipment and We pay a benefit equal to benefit payable according to the Schedule of Benefits , no further benefits will be provided for rental or purchase of the equipment;
   b. Burn garments (or burn anti-pressure garments) are covered only when prescribed by an Insured Person's Physician for treatment of third degree burns, deep second degree burns or for areas of the skin that have received a skin graft. Covered burn garments include gloves, face hoods, chin straps, jackets, pants, leotards, hose or entire body suits which provide pressure to burned areas to help with healing;
   c. Support stockings are covered for a diagnosis of phlebitis or other circulatory disease. Gradient pressure aids (stockings) are covered, provided that the stockings are prescribed by an Insured Person's Physician and are Medically Necessary. Anti-embolism stockings are not covered. Inelastic compression devices are not covered; benefits for covered gradient pressure aids include the Benefit for fitting of the garments. No additional benefits are available for fitting.
   d. Benefits are available for custom-fitted helmets or headbands (dynamic orthotic cranioplasty) to change the shape of an infant's head only when the service is provided for moderate to severe asymmetry (nonsynostotic plagiocephaly and brachycephaly) and the condition meets the definition of a Reconstructive Service. To be eligible for benefits , the service must be Medically Necessary and the infant Insured Person must be at least three months old, but no older than 18 months. Also, the infant must have completed at least two months of cranial repositioning therapy or physical therapy with no substantial improvement. Otherwise, no benefits are available for cranial helmets or any other device intended to change the shape of a child's head;
   e. Benefits are available for broad or narrow band ultraviolet light (UVB) home therapy equipment only if the therapy is conducted under a Physician's supervision with regularly scheduled exams. The therapy is covered only for treatment of the following skin disorders: severe atopic dermatitis and psoriasis, mild to moderate atopic dermatitis or psoriasis (when standard treatment has failed, as documented by medical records), lichen planus, mycosis fungoides, pityriasis lichenoides, pruritus of hepatic disease and pruritus of renal failure. UVB home therapy is not covered for any other skin disorder. Ultraviolet light A home therapy (UVA) is not covered. For information about ultraviolet light therapy, please see "Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders," in Section IV "Limitations and Exclusions," /"Limitations."

5. Exclusions. In addition to the other limitations and exclusions stated in the Policy, the following services are not covered. These exclusions apply, even if the services are provided, ordered or prescribed by a Physician and even if the services meet the definition of Medically Necessary.

   No benefits are available for:
   a. Arch supports, corrective shoes, foot orthotics (and fittings, castings or any services related to footwear or orthopedic devices) or any shoe modification;
   b. Special furniture, such as seat lift chairs, elevators (including stairway elevators or lifts), back chairs, special tables and posture chairs, adjustable chairs, bed boards, bed tables, and bed support devices of any type including adjustable beds;
   c. Glasses, sports bras, nursing bras and maternity girdles or any other special clothing, except as stated in this subsection;
   d. Nonprescription supplies, first aid supplies, ace bandages, cervical pillows, alcohol, peroxide, betadine, iodine, or phisohex solution; alcohol wipes, betadine or iodine swabs, items for personal hygiene;
   e. Bath seats or benches (including transfer seats or benches), whirlpools or any other bath tub, rails or grab bars for the bath, toilet rails or grab bars, commodes, raised toilet seats, bed pans;
   f. Heat lamps, heating pads, hydrocoliator heating units, hot water bottles, batteries and cryo cuffs
   g. (water circulating delivery systems);
   h. Biomechanical limbs, computers, physical therapy equipment, physical or sports conditioning equipment, exercise equipment, or any other item used for leisure, sports, recreational or vocational purposes, any equipment or supplies intended for educational or vocational rehabilitation, vehicles, scooters or any similar mobility device;
   i. Safety equipment, including hats, belts, harnesses, glasses or restraints;
   j. Costs related to residential or vocational remodeling or indoor climate/air quality control, air conditioners, air purifiers, humidifiers, dehumidifiers, vaporizers and any other room heating or cooling device or system;

k. Self-monitoring devices are not covered, except as stated in 2 "Diabetic Supplies" (above). No benefits are available for TENS units for incontinence, biofeedback devices, self-teaching aids, books, pamphlets, video tapes, video disks, fees for Internet sites or software, or any other media instruction or for any other educational or instructional material, technology or equipment,

Dentures, orthodontics, dental prosthesis and appliances. No benefits are available for appliances used to treat temporomandibular joint (TMJ) disorders.

Convenience Services are not covered under any portion of the Policy. Convenience Services include personal comfort items and any equipment, supply or device that is primarily for the convenience of an Insured Person, the Insured Person's family or a Physician.

Except as specified in this subsection and in any amendment to the Policy, no benefits are available for the cost of medical equipment, supplies, prosthetics, materials or devices.

5. Prescription Drugs

No health benefit plan that provides prescription drug benefits and establishes the specific sequence in which prescription drugs for a medical condition are to be prescribed shall require failure on the same medication on more than one occasion for patients continuously enrolled in the plan. Nothing in this section shall be construed to prevent a health care provider from prescribing a medication to the same patient on more than one occasion, when he or she determines it is medically appropriate. 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. In addition, benefits are payable for:

1. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA). We will not exclude this benefit provided that all of the following conditions have been met:
   a. The drug is approved by the FDA;
   b. The drug has been recognized for treatment of such indication in one of the standard reference compendia or 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., and b. of this benefit.
2. Prescription contraceptive drugs or devices.
3. An Insured Person who requires an expedited exception process for exigent circumstances will be notified of the decision to cover the prescription drug no later than 24 hours after the request is made. We will also notify the provider. An exigent circumstance occurs when the Insured Person is suffering from a health condition that may seriously jeopardize his or her life, health or ability to regain maximum function or if undergoing a course of treatment suing a non-formulary drug. In addition, an Insured Person may obtain coverage from a Medically Necessary non-formulary prescription drug in accordance to an expeditious exception process, not to exceed 48 hours. The exception process shall begin when the prescribing provider has submitted a request with a clinical rationale for the exception to the health benefit plan. A prescription that requires an exception for coverage shall be considered approved if the exception process exceeds 48 hours.

6. Important Information About Other Covered Medical Expenses

This subsection includes services that are covered and often involve Covered Medical Expenses defined elsewhere in this Section. For example, the "Organ and Tissue Transplants" described in D (below) involve Inpatient and Outpatient services described throughout subsection 1, "Inpatient Services" and 2, "Outpatient Services" (above in this Section).

The limitations and exclusions stated in this subsection are in addition to those stated in Section IV, "Limitations and Exclusions." Limitations and exclusions apply even if an Insured Person receives services from an Insured Person's Physician or according to an Insured Person's Physician's order or according to the recommendation of another Physician and even if the service meets the definition of Medical Necessity. No benefits are available for any services performed in conjunction with, arising from, or as a result of complications of a non-Covered Medical Expense. All of the plan rules, terms and conditions stated elsewhere in the Policy apply to the services in this subsection.

A. Dental Services

Dental Services. Dental Services are defined as any care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth. For the purposes of this subsection, Dental Services also include care of the temporomandibular joint (TMJ) to the extent stated below and Emergency Care in a hospital emergency room. Benefits are limited to 50% Coinsurance except for preventive pediatric dental care that is paid at 100% Coinsurance. The Deductible does not apply to this section.

Under the Policy, benefits are limited to the following Covered Dental Services. No other Dental Service is a Covered Medical Expense. Except as specifically stated in this subsection, Covered Medical Expenses must be approved *in advance* by an Insured Person's Physician. Otherwise, no benefits are available. The following Dental Services are Covered Medical Expenses:

1. Initial emergency treatment is received or authorized for accidental injury to sound natural teeth. Cost sharing amounts for emergency treatment are shown under parts I and II of the Schedule of Benefits, "Inpatient Services" and "Outpatient Services." No benefits are available for emergency treatment if an Insured Person damages his or her teeth or appliances as a result of biting or chewing. No benefits are available for emergency treatment to repair, restore or replace items such as fillings, crowns, caps or appliances that are damaged as a result of an Accident. Cost sharing amounts for Covered Inpatient and Outpatient Services are shown in the Schedule of Benefits.
2. Oral Surgery limited to the following:
   a. Surgical removal (extraction) of erupted teeth before radiation therapy for malignant disease. Services must be approved *in advance* by an Insured Person's Physician. Otherwise, no benefits are available. Benefits are limited to:

1) The surgeon's fee for the surgical procedure,
2) Intravenous sedation furnished by the operating dentist or oral surgeon,
3) General anesthesia furnished by a licensed anesthesiologist or anesthetist who is not the operating dentist or oral surgeon.

No benefits are available for related preoperative or postoperative care, including medical, laboratory and x-ray services. No benefits are available for related facility fees unless the provisions of 4 (below) apply.

b. Surgical correction of a facial bone fracture (not to include the portion of upper and lower jaws that contain the teeth, except as otherwise stated in this subsection) and surgical removal of a lesion or tumor by a dentist or oral surgeon are covered to the same extent as any other surgical procedure covered under the Policy. Services must be approved in advance by An Insured Person's Physician. Otherwise, no benefits are available.

Cost sharing amounts for covered oral surgery, anesthesia, office and facility care are shown in the Schedule of Benefits, "Inpatient Services" and "Outpatient Services."

3. Surgical correction or repair of the temporomandibular joint (TMJ). Surgical correction or repair of the TMJ is covered, provided that the Insured Person has completed at least five months of medically documented unsuccessful non-surgical treatment. The non-surgical treatment is not covered. Coverage is limited to surgical evaluation and surgical procedures that are Medically Necessary to correct or repair a disorder of the TMJ caused by (or resulting in) a specific medical condition such as degenerative arthritis, jaw fractures or jaw dislocations. Otherwise, no benefits are available. Administration of general anesthesia by a licensed anesthesiologist or anesthetist is covered in conjunction with a covered surgery. Medically Necessary Inpatient and Outpatient hospital care is covered in conjunction with a covered surgery, subject to all of the terms of the Policy. Cost sharing amounts for surgery, anesthesia and facility care are shown in the Schedule of Benefits, "Inpatient Services" and "Outpatient Services."

   Services must be approved *in advance* by an Insured Person's Physician. Otherwise, no benefits are available. Cost sharing amounts for surgery, anesthesia and facility care are in the Schedule of Benefits.

   Except as stated in this subsection, no benefits are available for diagnosis, evaluation or treatment of the TMJ. Diagnostic arthroscopy for TMJ disorders and trigger point injections are not covered. No benefits are available for non-surgical TMJ services. No benefits are available for x-rays of the teeth or orthopantagrams. Physical therapy for TMJ disorders is not covered. TMJ appliances or appliance adjustments are not covered. No benefits are available under any portion of the Policy for orthodontia, orthodontics, orthodontic care, dentures or dental prosthesis for TMJ disorders.

4. Benefits are available for hospital facility charges (Inpatient or Outpatient), surgical day care facility charges, dentist's office and general anesthesia furnished by a licensed anesthesiologist or anesthetist when it is Medically Necessary for certain Insured Persons to undergo a dental procedure under general anesthesia in a hospital facility, surgical day care facility or dentist's office. Insured Persons who are eligible for facility and general anesthesia benefits are:
   a. Children under the age of 6. The child's dental condition must be so complex that the dental procedure must be done under general anesthesia and must be done in a hospital or surgical day care facility setting. A licensed dentist and the child's Physician must determine *in advance* that anesthesia and hospitalization are Medically Necessary due to the complexity of the child's dental condition; or
   b. Insured Persons who have exceptional medical circumstances or a Developmental Disability. The exceptional medical circumstance or the Developmental Disability must be one that places the Insured Person at serious risk unless the dental procedure is done under general anesthesia and must be done in a hospital or surgical day care facility setting. The Insured Person's Physician must approve the services *in advance.*

      Cost sharing amounts for Inpatient and Outpatient facility charges and for general anesthesia are shown in the Schedule of Benefits. No benefits are available for a non-covered dental procedure, even when an Insured Person's Physician authorizes hospitalization and anesthesia for the procedure.

5. 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.

Diagnostic and Treatment Services:
Periodic oral evaluation - Limited to 1 every 6 months
Limited oral evaluation - problem focused - Limited to 1 every 6 months
Comprehensive oral evaluation - Limited to 1 every 6 months
Comprehensive periodontal evaluation - Limited to 1 every 6 months
Intraoral – complete series (including bitewings) 1 every 60 (sixty) months
Intraoral - periapical first film
Intraoral - periapical - each additional film
Intraoral - occlusal film
Bitewing - single film Adult -1 set every 6 months
Bitewings - two films -1 set every 6 months
Bitewings - four films -1 set every 6 months
Vertical bitewings – 7 to 8 films -1 set every 6 months
Panoramic film – 1 film every 60 (sixty) months
Cephalometric x-ray
Oral / Facial Photographic Images
Diagnostic Models

Preventive Services:
Prophylaxis - Limited to 1 every 6 months
Topical application of fluoride (excluding prophylaxis) – Limited to 2 every 12 months

Topical application of fluoride (excluding prophylaxis) – Age 15 to 19 - 2 every 12 months
Sealant - per tooth - unrestored permanent molars - 1 sealant per tooth every 36 months
Preventative resin restorations in a moderate to high caries risk patient - permanent tooth - 1 sealant per tooth every 36 months.
Space maintainer – fixed – unilateral
Space maintainer – fixed – bilateral
Space maintainer - removable – unilateral -
Space maintainer - removable – bilateral
Re-cementation of space maintainer
Additional Procedures covered as Basic Services: Palliative treatment of dental pain – minor procedure

Restorative Services:
Minor:
Amalgam - one surface, primary or permanent
Amalgam - two surfaces, primary or permanent
Amalgam - three surfaces, primary or permanent
Amalgam - four or more surfaces, primary or permanent Resin–based composite - one surface, anterior
Resin-based composite - two surfaces, anterior
Resin-based composite - three surfaces, anterior
Resin-based composite - four or more surfaces or involving incisal angle (anterior
Re-cement inlay
Re-cement crown
Prefabricated stainless steel crown - primary tooth – Under age 15 - Limited to 1 per tooth in 60 months
Prefabricated stainless steel crown - permanent tooth - Under age 15 - Limited to 1 per tooth in 60 months
Protective Restoration
Pin retention - per tooth, in addition to restoration

Restorative Services:
Major:
Detailed and extensive oral evaluation - problem focused, by report
Inlay - metallic – one surface – An alternate benefit will be provided
Inlay - metallic – two surfaces – An alternate benefit will be provided
Inlay - metallic – three surfaces – An alternate benefit will be provided
Onlay - metallic - two surfaces – Limited to 1 per tooth every 60 months
Onlay - metallic - three surfaces – Limited to 1 per tooth every 60 months
Onlay - metallic - four or more surfaces – Limited to 1 per tooth every 60 months
Crown - porcelain/ceramic substrate - Limited to 1 per tooth every 60 months
Crown - porcelain fused to high noble metal - Limited to 1 per tooth every 60 months
Crown - porcelain fused to predominately base metal – Limited to 1 per tooth every 60 months
Crown - porcelain fused to noble metal – Limited to 1 per tooth every 60 months
Crown - 3/4 cast high noble metal – Limited to 1 per tooth every 60 months
Crown - 3/4 cast predominately base metal – Limited to 1 per tooth every 60 months Crown - 3/4 porcelain/ceramic – Limited to 1 per tooth every 60 months
Crown - full cast high noble metal– Limited to 1 per tooth every 60 months
Crown - full cast predominately base metal – Limited to 1 per tooth every 60 months Crown - full cast noble metal– Limited to 1 per tooth every 60 months
Crown – titanium– Limited to 1 per tooth every 60 months
Core buildup, including any pins– Limited to 1 per tooth every 60 months
Prefabricated post and core, in addition to crown– Limited to 1 per tooth every 60 months Crown repair, by report

Endodontic Services - Minor:
Therapeutic pulpotomy (excluding final restoration) - If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development If a root canal is within 45 days of the pulpotomy, the pulpotomy is not a covered service since it is considered a part of the root canal procedure and benefits are not payable separately.
Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration) - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime.
Pulpal therapy (resorbable filling) - posterior, primary tooth excluding final restoration). Incomplete endodontic treatment when you discontinue treatment. - Limited to primary incisor teeth for members up to age 6 and for primary molars and cuspids up to age 11 and is limited to once per tooth per lifetime

Endodontic Services - Major:
Anterior root canal (excluding final restoration) Bicuspid root canal (excluding final restoration) Molar root canal (excluding final restoration) Retreatment of previous root canal therapy-anterior Retreatment of previous root canal therapy-bicuspid Retreatment of previous root canal therapy-molar
Apexification/recalcification–initial visit (apical closure/calcific repair of perforations, root resorption, etc.) Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)
Apexification/recalcification-final visit (includes completed root canal therapy, apical closure/calcific repair of perforations, root resorption, etc.)

Pulpal regeneration (completion of regenerative treatment in an immature permanent tooth with a necrotic pulp) does not include final restoration
Apicoectomy/periradicular surgery - anterior
Apicoectomy/periradicular surgery-bicuspid (first root)
Apicoectomy/periradicular surgery - molar (first root)
Apicoectomy/periradicular surgery (each additional root) Root amputation-per root
Hemisection (including any root removal)-not including root canal therapy

Periodontal Services:
Periodontal scaling and root planning-four or more teeth per quadrant – Limited to 1 every 24 months
Periodontal scaling and root planning-one to three teeth, per quadrant – Limited to 1 every 24 months
Periodontal maintenance – 4 in 12 months combined with adult prophylaxis after the completion of active periodontal therapy if under age 19.
Gingivectomy or gingivoplasty – four or more teeth - Limited to 1 every 36 months
Gingivectomy or gingivoplasty – one to three teeth
Gingival flap procedure, four or more teeth – Limited to 1 every 36 months Clinical crown lengthening-hard tissue
Osseous surgery (including flap entry and closure), four or more contiguous teeth or bounded teeth spaces per quadrant – Limited to 1 every 36 months
Pedicle soft tissue graft procedure
Free soft tissue graft procedure (including donor site surgery)
Subepithelial connective tissue graft procedures (including donor site surgery)
Full mouth debridement to enable comprehensive evaluation and diagnosis – Limited to 1 per lifetime

Prosthodontic Services -Minor:
Adjust complete denture – maxillary
Adjust complete denture – mandibular
Adjust partial denture – maxillary
Adjust partial denture - mandibular
Repair broken complete denture base
Replace missing or broken teeth - complete denture (each tooth)
Repair resin denture base
Repair cast framework
Repair or replace broken clasp
Replace broken teeth - per tooth
Add tooth to existing partial denture
Add clasp to existing partial denture
Rebase complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
Rebase maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Rebase mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete mandibular denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline maxillary partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture - Limited to 1 in a 36-month period 6 months after the initial installation
Reline complete maxillary denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial
Reline complete mandibular denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
Reline maxillary partial denture (laboratory) - Limited to 1 in a 36-month period 6 months after the initial installation
Reline mandibular partial denture (laboratory) Rebase/Reline - Limited to 1 in a 36-month period 6 months after the initial installation.
Tissue conditioning (maxillary) conditioning (mandibular)
Recement fixed partial denture
Fixed partial denture repair, by report

Prosthodontic Services - Major:
Complete denture - maxillary – Limited to 1 every 60 months
Complete denture - mandibular – Limited to 1 every 60 months
Immediate denture - maxillary – Limited to 1 every 60 months
Immediate denture - mandibular – Limited to 1 every 60 months
Maxillary partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
Mandibular partial denture - resin base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
Maxillary partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth)– Limited to 1 every 60 months
Mandibular partial denture - cast metal framework with resin denture base (including any conventional clasps, rests and teeth) – Limited to 1 every 60 months
Removable unilateral partial denture-one piece cast metal (including clasps and teeth) – Limited to 1 every 60 months
Note: An implant is a covered procedure of the plan only if determined to be a dental necessity.
Endosteal Implant - 1 every 60 months
Surgical Placement of Interim Implant Body - 1 every 60 months
Eposteal Implant – 1 every 60 months
Transosteal Implant, Including Hardware – 1 every 60 months

Implant supported complete denture
Implant supported partial denture
Connecting Bar – implant or abutment supported - 1 every 60 months Prefabricated Abutment – 1 every 60 months
Abutment supported porcelain ceramic crown -1 every 60 months
Abutment supported porcelain fused to high noble metal - 1 every 60 months
Abutment supported porcelain fused to predominately base metal crown - 1 every 60 months Abutment supported porcelain fused to noble metal crown - 1 every 60 months
Abutment supported cast high noble metal crown - 1 every 60 months
Abutment supported cast predominately base metal crown - 1 every 60 months
Abutment supported cast noble metal crown - 1 every 60 months
Implant supported porcelain/ceramic crown - 1 every 60 months
Implant supported porcelain fused to high metal crown - 1 every 60 months
Implant supported metal crown - 1 every 60 months
Abutment supported retainer for porcelain/ceramic fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for porcelain fused to noble metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast high noble metal fixed partial denture 1 every 60 months
Abutment supported retainer for predominately base metal fixed partial denture - 1 every 60 months
Abutment supported retainer for cast noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for ceramic fixed partial denture - 1 every 60 months
Implant supported retainer for porcelain fused to high noble metal fixed partial denture - 1 every 60 months
Implant supported retainer for cast metal fixed partial denture - 1 every 60 months
Implant/abutment supported fixed partial denture for completely edentulous arch - 1 every 60 months Implant/abutment supported fixed partial denture for partially edentulous arch - 1 every 60 months
Implant Maintenance Procedures -1 every 60 months
Repair Implant Prosthesis -1 every 60 months
Replacement of Semi-Precision or Precision Attachment -1 every 60 months
Repair Implant Abutment -1 every 60 months
Implant Removal -1 every 60 months
Implant Index -1 every 60 months
Pontic - cast high noble metal – Limited to 1 every 60 months
Pontic - cast predominately base metal – Limited to 1 every 60 months
Pontic - cast noble metal– Limited to 1 every 60 months
Pontic – titanium – Limited to 1 every 60 months
Pontic - porcelain fused to high noble metal – Limited to 1 every 60 months
Pontic - porcelain fused to predominately base metal – Limited to 1 every 60 months Pontic - porcelain fused to noble metal – Limited to 1 every 60 months
Pontic - porcelain/ceramic – Limited to 1 every 60 months Inlay/onlay – porcelain/ceramic – Limited to 1 every 60 months Inlay – metallic – two surfaces – Limited to 1 every 60 months
Inlay – metallic – three or more surfaces - Limited to 1 every 60 months
Onlay – metallic – three surfaces - 1 every 60 months
Onlay – metallic – four or more surfaces -1 every 60 months
Retainer - cast metal for resin bonded fixed prosthesis -1 every 60 months
Retainer - porcelain/ceramic for resin bonded fixed prosthesis -1 every 60 months
Crown - porcelain/ceramic -1 every 60 months
Crown - porcelain fused to high noble metal - 1 every 60 months
Crown - porcelain fused to predominately base metal - 1 every 60 months
Crown - porcelain fused to noble metal - 1 every 60 months
Crown - 3/4 cast high noble metal - 1 every 60 months
Crown - 3/4 cast predominately base metal - 1 every 60 months
Crown - 3/4 cast noble metal - 1 every 60 months
Crown - 3/4 porcelain/ceramic - 1 every 60 months
Crown - full cast high noble metal - 1 every 60 months
Crown - full cast predominately base metal - 1 every 60 months Crown - full cast noble metal - 1 every 60 months
Core buildup for retainer, including any pins - 1 every 60 months Occlusal guard, by report - 1 in 12 months for patients 13 and older

Oral Surgery:
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)
Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
Removal of impacted tooth - soft tissue
Removal of impacted tooth – partially bony
Removal of impacted tooth - completely bony
Removal of impacted tooth - completely bony with unusual surgical complications
Surgical removal of residual tooth roots (cutting procedure)

Coronectomy - intentional partial tooth removal
Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
Surgical access of an unerupted tooth
Alveoloplasty in conjunction with extractions - per quadrant
Alveoloplasty in conjunction with extractions-one to three teeth or tooth spaces, per quadrant Alveoloplasty not in conjunction with extractions - per quadrant
Alveoloplasty not in conjunction with extractions-one to three teeth or tooth spaces, per quadrant
Removal of exostosis
Incision and drainage of abscess - intraoral soft tissue Suture of recent small wounds up to 5 cm
Excision of pericoronal gingiva
Oral Surgery Services Not Covered:
In addition to any other policy exclusions, the following services are not covered:

- Surgical replacement screw retained
- Surgical replacement w/surgical flap
- Surgical replacement without the surgical flap
- TMJ Appliance
- TMJ Therapy
- Sinus Augmentation with bone or bone substitutes
- Appliance Removal
- Intraoral placement of a fixation device

Orthodontics:
The waiting period for orthodontic services is 24 months. To meet this requirement, the Dependent Child receiving orthodontic services must be covered under the same plan option for the entire 24 month waiting period and continue orthodontia benefits in that same orthodontia plan option. Orthodontics must be Medically Necessary.
Limited orthodontic treatment of the primary dentition
Limited orthodontic treatment of the transitional dentition
Limited orthodontic treatment of the adolescent dentition Interceptive orthodontic treatment of the primary dentition
Interceptive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the transitional dentition
Comprehensive orthodontic treatment of the adolescent dentition
Removable appliance therapy
Fixed appliance therapy
Pre-orthodontic treatment visit
Periodic orthodontic treatment visit (as part of contract)
Orthodontic retention (removal of appliances, construction and placement of retainer(s)
Orthodontic Services Not Covered:
In addition to any other policy exclusions, the following services are not covered:

- Repair of damaged orthodontic appliances
- Replacement of lost or missing appliance
- Orthodontic services provided to a dependent of an enrolled member who has not met the 24 month waiting period requirement.
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedures include, but are not limited to, equilibration, periodontal splinting, full mouth rehabilitation, and restoration for misalignment of teeth.
- Treatment not considered Medically Necessary.

Additional dental services not covered under the Policy:

- Any dental service not specifically covered under this Pediatric Dental benefit
- Adjunctive pre-diagnostic test
- Declassification procedure
- Special stains for microorganisms
- Special stains not for microorganisms Immunohistochemical stains
- Tissue in-situ-hybridization1 Electron microscopy
- Direct immunofluorescence
- In-direct immunofluorescence
- Consultation on slides prepared elsewhere
- Consultation including preparation of slides
- Accession
- Transepithelial
- Nutritional counseling Tobacco counseling
- Oral Hygiene Instruction
- Removal of fixed space maintainer
- Gold Foil surfaces
- Provisional Crown Post Removal
- Temporary Crown
- Coping

- Endodontic Implant Intentional reimplantation
- Surgical procedure for isolation of tooth
- Canal preparation
- Anatomical crown exposure 4 or more teeth
- Anatomical crown exposure 1-3 teeth
- Splinting intracoronal
- Splinting extracoronal
- Complete denture upper (interim)
- Complete denture lower (interim)
- Partial denture upper (interim)
- Partial denture lower (interim)
- Precision Attachment
- Replacement Precision Attachment
- Fluoride Gel Carrier
- Custom abutment Provisional Pontic
- Interim pontic
- Interim retainer crown
- Connector bar
- Stress breaker
- Precision Attachment
- Coping - metal

Limitations and Exclusions for Dental Services:

In addition to the "Limitations and Exclusions" stated in Section IV , the following limitations and exclusions apply to Dental Services:

a. Except as specifically stated in 1 to 5 above, no benefits are available for facility fees, professional fees, anesthesia related to Dental Services or any other care relating to the teeth and supporting structures, such as the gums, tooth sockets in the jaw and the soft or bony portions of upper and lower jaws that contain the teeth. Except as specifically stated in 3 above, no benefits are available for any service relating to care of the temporomandibular joint (TMJ). Except as stated in 4 (above) for facility and general anesthesia services, no benefits are available for treatment of cavities or care of the gums. No benefits are available for any condition that is related to, arising from or is a complication of a non-Covered Medical Expense.
b. The maximum benefit payable for surgery includes the Benefit payment for IV sedation and/or local anesthesia. For any surgical Dental Service covered under this subsection, no benefits beyond the surgical maximum benefit payable are available for IV sedation and/or local anesthesia.
c. Except as stated in 4 above, no benefits are available for treatment or evaluation of a periodontal disorder, disease or abscess. Osseous and flap procedures, scaling, root planning, prophylaxis and periodontal evaluations are not covered.
d. No benefits are available for preventive Dental Services, except under the Pediatric Dental Benefit.
e. Except as stated in 1 and 4 above in this subsection, no benefits are available for restorative Dental Services, even if the underlying dental condition affects other health factors. No benefits are available for non-Covered dental procedures, even when an Insured Person's Physician authorizes hospitalization and general anesthesia covered under this subsection.
f. X-rays of the teeth are covered only when the terms of 1 (above) are met. Otherwise, x-rays of the teeth are not covered under any portion of the Policy. Orthopantagrams are not covered.
g. Orthodontia, braces, false teeth and biofeedback training are not covered under the Policy. Orthopedic repositioning splints and occlusal adjustments are not covered under the Policy.
h. Night guards, trismus appliances, bruxism splints or occlusal guards are not covered under any portion of the Policy.
i. No benefits are available for local anesthesia services. Except as specifically stated in this subsection and in item 4 above, no benefits are available for office services, anesthesia services or facility fees. Except as stated in item 4 above in this subsection, no benefits are available for surgical exposure of impacted teeth to aid eruption, osseous and flap procedures, scaling, root planning, tooth build up, prophylaxis and periodontal evaluations.
j. No benefits are available for biofeedback training.
k. No benefits are available for diagnostic arthroscopy.

B. Hearing Services

Benefits are available for *diagnosis and treatment of ear disease or injury*. An Insured Person's Physician must find or suspect injury to the ear or a diseased condition of the ear. Otherwise, no benefits are available. No benefits are available for hearing aids except as stated in subsection 4 E, "Durable Medical Equipment, Medical Supplies and Prosthetics." "Covered Medical Expenses" (Inpatient and Outpatient care) are described throughout Section III- DESCRIPTION OF BENEFITS. Cost sharing amounts are shown in the Schedule of Benefits.

Except as stated in subsection 2 "Outpatient Service," A "Preventive Care," "Routine hearing exams," no benefits are available for *routine* hearing services to determine the need for hearing correction.

C. Infertility Diagnostic Services

Benefits are available for diagnostic services to determine the cause of medically documented infertility. Benefits also include services to treat the underlying medical conditions that cause infertility. For the purposes of determining Benefit availability, "infertility" is defined as the diminished or absent capacity to create a pregnancy. Infertility may occur in either a female or a male.

Infertility may be suspected when a presumably healthy woman who is trying to conceive does not become pregnant after her uterus has had contact with sperm during 12 ovulation cycles in a period of up to 24 consecutive months, as medically documented. For women over age 35, infertility may be suspected after a woman's uterus has had contact with sperm during six ovulation cycles in a period of up to 12 consecutive months, as medically documented. Please note that menopause in a woman is considered a natural condition and is not considered "infertility" for the purposes of determining benefit availability under this health plan.

To be eligible for benefits, Covered Medical Expenses must be Medically Necessary.

1. Covered Medical Expenses. Benefits are available for the following Covered Medical Expenses to determine the cause of medically documented infertility:
   a. Medical exams;
   b. Laboratory tests, including sperm counts and motility studies, sperm antibody tests, cervical mucus penetration tests and endometrial biopsy;
   c. Surgical procedures such as diagnostic laparoscopy; and
   d. Ultrasound and other imaging exams, such as hysterosalpingography to determine the cause of infertility or to establish tubal patency.

   Covered Medical Expenses may be provided to male or female Insured Persons. Coverage is not available to partners who are not Insured Persons. Benefits for Covered Medical Expenses are subject to cost sharing amounts as shown in the Schedule of Benefits for medical exams, laboratory and x-ray tests, surgery and anesthesia.
2. Limitations and Exclusions. Except as stated above, no benefits are available under the terms of the Policy for any service to diagnose or treat infertility or for any care (Inpatient or Outpatient) related to a non-Covered Medical Expense.

   No benefits are available under any portion of the Policy for the following services or for any care related to these services:
   a. Medical exams, consultations and surgical procedures to treat or correct the cause of infertility or to treat or correct medical conditions contributing to infertility;
   b. Male or female fertility drugs and hormones, and any service to prescribe or monitor the use of fertility drugs or hormones;
   c. Medical care, sonograms (ultrasounds), laboratory services, radiological services or any other service related to treatment of infertility;
   d. Egg or sperm procurement, harvesting or processing (including donor services), egg or sperm banking, storage or, microfertilization (egg drilling or tweaking) and electroejaculation procedures;
   e. Intracervical or intrauterine (IUI) artificial insemination (AI), using the partner's sperm (AIH) or donor sperm (AID);
   f. Assisted reproduction technology (ART) such as intravaginal culture, in-vitro fertilization and embryo transfer (IVF-ET) such as natural oocyte retrieval (NORIF or NORIVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT);
   g. Cryopreservation of donor eggs, cryopreservation of embryos or cryopreserved embryo transfer (CET), intracytoplasmic sperm injection (ICSI), preimplantation genetic diagnosis (PGD);
   h. To be eligible for benefits, neither partner can have undergone a previous voluntary or elective sterilization procedure. No benefits are available for services to reverse voluntarily induced sterility or for diagnosis or treatment following the sterilization or sterilization reversal (successful or unsuccessful);
   i. Any services or supplies provided to a person not covered under the Policy in connection with a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple);
   j. Sex selection, genetic engineering, sperm penetration assays, microvolume straw technique, hamster penetration test (SPA),
   k. Any infertility procedure performed during an operation not related to an infertility diagnosis;
   l. Culture and fertilization of oocytes, co-culture of embryos and assisted embryo hatching;
   m. Direct intraperitoneal insemination (DIPI), peritoneal ovum and sperm transfer (POST),
   n. Costs related to donor eggs for or from women with genetic oocyte defects, or donor sperm for or from men with genetic sperm defects;
   o. Supplies (such as thermometers and kits to predict ovulation); or
   p. Menopause in a woman is considered a natural condition and is not considered to be infertility, as defined above. No benefits are available for infertility diagnosis, procedures or treatment for a woman who is menopausal or perimenopausal (or for their male partners), unless the woman is experiencing menopause at a premature age.

   Except as stated in this subsection, no benefits are available for any services to diagnose the cause of infertility or to treat infertility. No benefits are available for any service that is an Experimental/Investigational Service, as defined in Section IV, LIMITATIONS AND EXCLUSIONS/ Exclusions. No benefits are available for any service that is not Medically Necessary.

   Benefits are subject to all of the terms and conditions of the Policy including Copayment, Deductible, and Coinsurance, requirements, Medical Necessity and the limitations, exclusions, and other party liability rules stated in the Policy.

   An Insured Person has the right to appeal Benefit determinations made by Us, including Adverse Determinations regarding coverage for Infertility Services. For complete information, please see Section VII – APPEALS PROCEDURE.

D. Organ and Tissue Transplants

The organ recipient must be an Insured Person. When the organ donor is an Insured Person, and the recipient is a not an Insured Person, no benefits are available for services received by the donor or by the recipient. Exception: Human leukocyte antigen testing (histocompatibility locus antigen testing) to screen for A, B and DR antigens for the purposes of identifying an Insured Person as a potential bone marrow transplant donor is covered, even if there is no specified recipient at the time of screening and/or an identified recipient is not an Insured Person. This screening for potential donors is covered only if, at the time of the testing:

1. The Insured Person who undergoes the screening signs an informed consent form authorizing use of the results for the Insured Person's participation in the National Marrow Donor Program; and
2. The screening shall be performed in a facility that is accredited by the American Association of Blood Banks, or the College of American Pathologists, or their successors, or any other national accrediting body with requirements that are substantially equivalent to or more stringent than those of the College of American Pathologists, and is licensed under the Clinical Laboratory Improvement Act of 1967, 42 U.S.C. section 263a. Otherwise, no benefits are available for human leukocyte antigen testing to identify potential bone marrow transplant donors when the recipient is not an Insured Person.

Benefits are available only if an Insured Person meets all of the criteria for transplant eligibility as determined by the Physician. The transplant must be generally considered the treatment of choice by the Physician. Otherwise, no benefits are available. Transplants are not covered for patients with certain systemic diseases, contraindications to immunosuppressive drugs, positive test results for HIV (with or without AIDS), active infection, active drug, alcohol or tobacco use or behavioral or psychiatric disorders likely to compromise adherence to strict medical regimens and post-transplant follow-up.

Covered Medical Expenses. The following transplants are covered if all of the conditions stated in this subsection are met.

1. Cornea, heart, heart-lung, kidney, kidney-pancreas, liver, and pancreas;
2. Allogeneic (HLA identical match) bone marrow transplants for acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (for children who are at least one year old), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteopetrosis, severe combined immunodeficiency, Thalassemia major and Wiskott-Aldrich syndrome;
3. Autologous bone marrow (autologous stem cell support) transplants and autologous peripheral stem cell support transplants for acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Autologous bone marrow transplants are covered for breast cancer;
4. Single or double lung transplants for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension and emphysema. Double lung transplants are covered for cystic fibrosis; and
5. Small bowel transplants for Insured Persons with short bowel syndrome when there is irreversible intestinal failure, an established TPN (total parenteral nutrition) dependence for a minimum of two years, or there is evidence of severe complications from TPN. Simultaneous small bowel/liver transplants are covered for children and adults with short bowel syndrome when there is irreversible intestinal failure, an established TPN dependence for a minimum of two Policy Years, evidence of severe complications from TPN or evidence of impending end-stage liver failure.

Benefits are available for the tissue typing, surgical procedure, storage expense and transportation costs directly related to the donation of a human organ or other human tissue used in a covered transplant procedure. Benefits shall also provide reimbursement for any medical expenses of a live donor to the extent that benefits remain and are available under the Policy, after benefits for the Insured Person's own expenses have been paid. Finally, We will pay $150 for laboratory fee expenses arising from human leukocyte antigen testing.

Covered Medical Expenses (Inpatient and Outpatient) are stated throughout Section III- DESCRIPTION OF BENEFITS. Covered Medical Expenses are subject to any limits shown in the Schedule of Benefits.

No benefits are available for any transplant procedure that is not a Covered Medical Expense as described in this subsection. Experimental/ Investigational transplant procedures and any related care (including care for complications of a non- covered procedure) are not covered except as stated in E, below for "Qualified Clinical Trials." No benefits are available for procedures that are not Medically Necessary. No benefits are available for any service or supply related to surgical procedures for artificial or nonhuman organs or tissues. No benefits are available for transplants using artificial parts or nonhuman donors. Benefits are not provided for services and supplies related to artificial and/or mechanical hearts or ventricular and/ or atrial assist devices related to a heart condition or for subsequent services and supplies for a heart condition as long as any of the above devices remain in place. This exclusion includes services for implantation, removal and complications. This exclusion does not apply to Left Ventricular Assist Devices when used as a bridge to a human heart transplant.

E. Qualified Clinical Trials: Routine Patient Care

Benefits are available for Medically Necessary Routine Patient Care related to drugs and devices that are the subject of clinical trials, provided that all of the following terms and conditions are met:

1. The drug or device under study must be approved for sale by the FDA (regardless of indication).
2. The drug or device under study must be for cancer or any other life-threatening condition.
3. The drug or device must be the subject of a clinical trial approved by one of the following:
   - One of the National Institutes of Health (NIH),
   - An NIH cooperative group or an NIH center,
   - The FDA (in the form of an Investigational new drug application or exemption),
   - The federal department of Veterans Affairs or Defense, or
   - An institutional review board of an institution in New Hampshire that has a multiple assurance contract approved by the Office of Protection from Research Risks of the NIH.
4. Standard treatment has been or would be ineffective, does not exist or there is no superior non- Investigational treatment alternative.
5. The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training and volume of patients treated to maintain expertise.
6. The available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the non-Investigational alternative.
7. For phase III or IV clinical trials (clinical trials involving leading therapeutic or diagnostic alternatives) benefits are available for Routine Patient Care, provided that all of the conditions stated in this subsection are met, and subject to all of the other terms and conditions of the Policy.
8. For phase I or II clinical trials (clinical trials involving emerging technologies), Benefits are available for Routine Patient Care only if
   - All of the conditions stated in this subsection are met and subject to all of the other terms and conditions of the Policy, and
   - We review all of the information available regarding an Insured Person's individual participation in a Phase I or II clinical trial and determine that benefits will be provided for An Insured Person's Routine Patient Care.

Routine Patient Care means the Medically Necessary Covered Medical Expenses described in the Policy for which benefits are regularly available, no applicable exclusion is stated in the Policy and for which reimbursement is regularly made to a Physician. For example, if surgery is Medically Necessary to implant a device that is being tested in a phase III or IV clinical trial, the surgery and any Medically Necessary hospital care are covered according to the terms and conditions of the Policy. Plan rules and cost sharing rules apply to Routine Patient Care as for any other similar service. Cost sharing amounts for Routine Patient Care costs are shown in the applicable parts of the Schedule of Benefits.

Routine Patient Care does not include:

1. The drug or device that the trial is testing;
2. Experimental/Investigational drugs or devices not approved for market for any indication by the FDA;
3. Non-health care services that an Insured Person may be required to receive in connection with the clinical trial or services that are provided to an Insured Person for no charge;
4. Services that are clearly inconsistent with widely accepted and established regional or national standards of care for a particular diagnosis;

5. The cost of managing the research associated with the clinical trial. No benefits are available for items or services provided primarily to collect data, and not used in the direct provision of Medically Necessary health care services. For example, monthly CT scans for a condition that usually requires fewer scans are not Routine Patient Care,
6. Services that are not Medically Necessary; or
7. Any service not specifically stated as a Covered Medical Expense in the Policy. Services subject to an exclusion or limitation stated in the Policy are not Routine Patient Care.

F. Required Exams or Services

No benefits are available for examinations or services that are ordered by a third party and are not Medically Necessary to treat a sickness or injury that an Insured Person's Physician finds or reasonably suspects. No benefits are available for examinations or services required to obtain or maintain employment, insurance or professional or other licenses. No benefits are available for examinations for participation in athletic or recreational activities or for attending a school, camp, or other program, unless furnished during a covered medical exam, as described in Section III- DESCRIPTION OF BENEFITS. Court ordered examinations or services are covered, provided that the services are Medically Necessary Covered Medical Expenses furnished by a Physician. Covered Medical Expenses are subject to the cost sharing amounts as shown in the Schedule of Benefits.

G. Surgery

Benefits are available for covered surgical procedures, including the services of a surgeon, specialist, anesthetist or anesthesiologist and for pre-operative and postoperative care. A Surgical Assistant is a Physician acting within the scope of his or her license who actively assists the operating surgeon in performing a covered surgical service. Benefits are available for the Medically Necessary services of a Surgical Assistant, provided that the surgery is a Covered Medical Expense the use of an Assistant Surgeon is Medically Necessary.

Administration of general anesthesia is covered, provided that:

1. The surgery is a Covered Medical Expense, and
2. The anesthesia is administered by a licensed anesthesiologist or anesthetist who is not the surgeon. Surgery includes correction of fractures and dislocations, delivery of a baby, endoscopies and any incision or puncture of the skin or tissue that requires the use of surgical instruments to provide a Covered Medical Expense. Covered Services are subject to the cost sharing amounts shown in the Schedule of Benefits.

Under the terms of this subsection, surgery does not include: inoculation, vaccination, collection of blood or administration or injection of drugs or trigger point injections for treatment of TMJ disorders. Surgery does not include any service excluded from coverage under the terms of the Policy.

Limitations. In addition to the limitations and exclusions stated elsewhere in the Policy, the following limitations apply to surgery:

1. Reconstructive surgery. Benefits are available for Medically Necessary reconstructive surgery only if at least one of the following criteria is met. Reconstructive surgery or services must be:
   - Made necessary by accidental injury; or
   - Necessary for reconstruction or restoration of a functional part of the body following a covered surgical procedure for disease or injury; or
   - Medically Necessary to restore or improve a bodily function, or
   - Necessary to correct congenital disease or anomaly for covered dependent children who have functional physical deficits due to the congenital disease or anomaly. Corrective surgery for children who do not have functional physical deficits due to the congenital disease or anomaly is not covered under any portion of the Policy.
   - Benefits are available for breast reconstruction following mastectomy for patients who elect reconstruction. Breast reconstruction can include reconstruction to both effected breasts or one effected breast. Reconstruction can also include reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast (to produce a symmetrical appearance) in the manner chosen by the patient and the Physician.

   Reconstructive surgery or procedures or services that do not meet at least one of the above criteria is not covered under any portion of the Policy. Provided that the above definition of reconstructive surgery is met, the following reconstructive surgeries are eligible for benefits:
   - Mastectomy for Gynecomastia
   - Mandibular/Maxillary orthognathic surgery
   - Port wine stain removal

   Benefits are available based on the criteria stated in the Policy. Please see subsection 4 E "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about coverage for helmets or adjustable bands used to change the shape of an infant's head.
2. Cosmetic Services. Cosmetic Services are not covered under any portion of the Policy. Please see Section IV "Limitations and Exclusions", II "Exclusions" for a definition of Cosmetic Services.
3. Dental Services. Dental Services are covered only as stated in A, "Dental Services" (above). Except as stated in A (above), no benefits are available for Dental Services, including dental surgery, under any portion of the Policy.
4. Surgery for conditions caused by obesity. Benefits are available for bariatric surgery that is Medically Necessary for the treatment of diseases and ailments caused by or resulting from obesity or morbid obesity. When applying the definition of Medical Necessity to bariatric surgery services, Our administrator's or Our standards are consistent with qualification and treatment criteria set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons.

   Surgery to treat the condition of obesity itself or morbid obesity itself is not covered under any portion of the Policy, even if the surgery, service or program is ordered by An Insured Person's Physician or performed or ordered by another Designated Provider. This exclusion applies even if the surgery, service or program meets the definition of Medical Necessity. Except as stated in this subsection, no benefits are available for bariatric surgery or any other surgery intended to manage or control appetite or body weight.

   Please see "Diabetes Management Programs" and "Nutrition counseling" in subsection 2 "Outpatient Services," A "Preventive Care" and "Outpatient/office visits" "Covered Medical Expenses" for information about benefits for non- surgical services for weight management, management of obesity and treatment of the diseases and ailments caused by or resulting from obesity.

   No benefits are available for weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in the Policy. This exclusion includes commercial weight loss programs (such as Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.

5. Postoperative medical care. The maximum benefit payable for surgery includes the benefit payment for postoperative medical care. No benefits beyond the surgical maximum benefit payable are available for surgery-related postoperative medical care.
6. Organ/tissue transplant surgery. Please see subsection D, "Organ and Tissue Transplants" (above in this subsection) for important information about coverage and limitations for organ/tissue transplant surgery.
7. Intravenous (IV) Sedation and local anesthesia. The maximum benefit payable for surgery includes the Benefit payment for IV sedation and/or local anesthesia. No benefits beyond the surgical maximum benefit payable are available for IV sedation and/or local anesthesia.
8. Surgery related to non-Covered Medical Expenses. No benefits are available for surgery or any other care related to, resulting from, arising from or provided in connection with non-Covered Medical Expenses or for complications arising from non-Covered Medical Expenses. This exclusion applies even if the service is furnished or ordered by an Insured Person's Physician or other Physician and meets the definition of Medical Necessity.

H. Vision Services

Benefits are available for *diagnosis and treatment of eye disease or injury*. Covered Medical Expenses (Inpatient and Outpatient care) are described throughout this Section with the exception of Pediatric Vision Benefits that follow. Cost sharing amounts are shown in item 2 of the Schedule of Benefits.

Except for routine vision exams as stated below in the Pediatric Vision Benefit, no benefits are available for *routine* vision care to determine the need for vision correction or for the prescription and fitting of corrective lenses, including contact lenses, except if payable under the Pediatric Vision Benefit.

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. Preventive care is treated as any other preventive care as shown in item 2 of the Schedule of Benefits.

1. 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:
   a. Case history;
   b. External examination of the eye or internal examination of the eye;
   c. Opthalmoscopic exam;
   d. Determination of refractive status;
   e. Binocular distance;
   f. Tonometry tests for glaucoma;
   g. Gross visual fields and color vision testing; and
   h. Summary findings and recommendation for corrective lenses.
2. 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.

I. Autism Services

Benefits are available for the treatment of pervasive developmental disorder or autism. To determine if the services are Medically Necessary, We may require submission of a treatment plan signed by the Insured Person's Physician, an appropriately credentialed treating specialist, a child psychiatrist, a pediatrician with a specialty in behavioral-developmental pediatrics, a neurologist with a specialty in child neurology or a licensed psychologist with training in child psychology. We will review the treatment plan no more than once every six months unless Insured Person's provider changes the treatment plan. Covered services include:

1. Direct or consultative services provided by a licensed professional including a licensed psychiatrist, licensed advance practice registered nurse, licensed psychologist or licensed social worker.
2. Physical, occupational and speech therapy provided by a licensed physical or occupational therapist or by a licensed speech and language pathologist to develop skill or function or to prevent the loss of attained skill or function. As applicable, any visit limits for other physical, speech and occupational therapy, will not apply to physical, occupational or speech therapy to treat pervasive developmental disorder or autism,
3. Prescription drugs, subject to the terms and conditions stated in the Prescription Drugs benefit.
4. Applied behavioral analysis to treat pervasive developmental disorder or autism. Applied behavior analysis means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in behavior, including the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

   Applied behavior analysis must be furnished by an individual who is professionally certified by a national board of behavior analysts or the services must be performed under the supervision of a person professionally certified by a national board of behavior analysts. Otherwise, no benefits are available for applied behavior analysts.

SECTION IV – LIMITATIONS AND EXCLUSIONS

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.

Limitations

The following are important limitations that apply to the Covered Medical Expenses stated in Section III- DESCRIPTION OF BENEFITS. In addition to other limitations, conditions or exclusions set forth elsewhere in the Policy, benefits for expenses related to the services, supplies, conditions or situations described in this sub-section are limited as indicated below. Limitations apply to these items and services even if an Insured Person receives them from an Insured Person's Physician or according to a Referral from an Insured Person's Physician.

The Policy does not cover any service or supply not specifically listed as a Covered Medical Expense in the Policy. The following list of limitations is not a complete list of all services, supplies, conditions or situations for which benefits are limited. Limitations are stated throughout the Policy. If a service is not covered, then all services performed in conjunction with, arising from, or as a result of complications to that service is not covered.

We make determinations about Medical Necessity, Experimental/Investigational Services and new technology based on the terms of the Policy, including the definition of Medical Necessity. An Insured Person the right to appeal Benefit determinations made by Us, including Adverse Determinations regarding Medical Necessity. For complete information about the appeal process, please see Section VII – APPEALS PROCEDURE.

A. Human Growth Hormones. No benefits are available for human growth hormones, except:
   1. To treat children with short stature who have an absolute deficiency in natural growth hormone, or
   2. To treat children with short stature who have chronic renal insufficiency and who do not have a functioning renal transplant.

   Benefits are subject to the cost sharing amounts as shown under section 2 "medical supplies" or section 3, "Infusion Therapy," depending on the Physician of the services.

B. Private Room. If an Insured Person occupies a private room, he or she will have to pay the difference between the hospital's charges for private room and the hospital's most common charge for a semi-private room, unless it is Medically Necessary for such person to occupy a private room. An Insured Person's Physician must provide Our administrator or Us with a written statement regarding the Medical Necessity of an Insured Person's use of a private room. We will determine Medical Necessity, and Our administrator or Us must agree *in advance* that private room accommodations are Medically Necessary. For emergency treatment We will give the Insured Person 48 hours following the admission within which to request authorization for the private room accommodation. Covered private room charges are subject to the cost sharing amounts as shown under part I of the Schedule of Benefits.

C. Ultraviolet Light Therapy and Ultraviolet Laser Therapy for Skin Disorders. Benefits are available for out-of-home ultraviolet light and laser therapy as follows:
   1. Ultraviolet light therapy is covered for treatment of atopic dermatitis, chronic urticaria, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), pityriasis lichenoides, pityriasis rosea, pruritus of renal failure, psoriasis or vitiligo.
   2. Psoralen with Ultraviolet A light therapy is covered for treatment of acute or chronic pityriasis lichenoides, atopic dermatitis, eczema, lichen planus, mycosis fungoides (cutaneous T-cell lymphoma), psoriasis and vitiligo.
   3. Ultraviolet laser therapy for the treatment of inflammatory skin disorders such as psoriasis, provided that:
   4. The inflammation is limited to less than or equal to 10% of the Insured Person's body surface area, and
   5. The Insured Person has undergone conservative therapy with topical agents, with or without standard non-laser ultraviolet light therapy and the conservative therapy was not successful as documented in medical records.

   Except as stated in this subsection, no benefits are available for ultraviolet light or laser therapy for skin disorders. Please Section III- DESCRIPTION OF BENEFITS, E "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about coverage for home ultraviolet light therapy for skin disorders. Except as stated in Section 6 "Covered Medical Expenses" and in this subsection, no benefits are available for ultraviolet light therapy or ultraviolet laser therapy for skin disorders.

Exclusions

No benefits are available for the following items or services. This subsection is not a complete list of all non-Covered Medical Expenses. Other limitations, conditions and exclusions set forth elsewhere in the Policy. Please remember, this health plan does not cover any service or supply not specifically listed as a Covered Medical Expense in the Policy. All Medically Necessary services for major medical are covered except the services that are explicitly excluded in the provisions below.

We make determinations about Medical Necessity, Experimental/Investigational services and new technology based on the terms of the Policy, including the definition of Medical Necessity found in Section I "Definitions." An Insured Person has the right to appeal Benefit determinations made by Our designated representative or Us, including Adverse Determinations regarding Medical Necessity. For complete information about the appeal process, please see Section VII – APPEALS PROCEDURE.

No benefits are available for the cost of any non-Covered Medical Expenses or for the cost of any care related to, resulting from, arising from or provided in connection with non-Covered Medical Expenses or for complications arising from non-Covered Medical Expenses. The limitations and exclusions found in this subsection of the Policy and in any other portion of the Policy apply even if the service is furnished or ordered by An Insured Person's Physician or other Physician and/or the service meets The definition of Medical Necessity.

Alternative Medicines or Complementary Medicine. No benefits are available for alternative or complementary medicine, even if the service is recommended by the Insured Person's Physician and even if the services are beneficial to such person. Alternative or complementary medicine is any protocol or therapy for which the clinical effectiveness has not been proven, established or medically documented or otherwise fails to meet the definition of Medical Necessity. Services in this category include acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage therapy, reike therapy, herbal, vitamin or dietary products or therapies, thermography, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST) and iridology-study of the iris.

Artificial Insemination. In general terms, "artificial insemination" refers to insemination by any means other than natural sexual intercourse. No benefits are available under any portion of the Policy for artificial insemination.

Biofeedback Services. Biofeedback services are not covered.

Blood and Blood Products. No benefits are available for costs related to the donation, drawing or storage of designated blood. Designated blood is blood that is donated and then designated for a specific person's use at a later date. No benefits are available for blood, blood donors, blood products or packed red blood cells when participation in a volunteer blood program is available.

Care Furnished by an Immediate Family Member. No benefits are available for care furnished by an Immediate Family Member.

Care Received When An Insured Person is Not Covered Under The Policy. No benefits are available for any service that an Insured Person receives before the effective date of the Policy.

If an Inpatient admission begins before the effective date of the Policy and this coverage replaces that of a prior carrier, benefits will be provided under the Policy for Inpatient days occurring on or after the effective date of the Policy, unless the terms of the prior carrier's Policy or policy provide cover-

age for the entire admission (admission date to discharge date), and subject to all of the terms and conditions of the Policy for Medically Necessary Inpatient services.

Except as stated in the Extension of Benefits provision, benefits are not available for Inpatient days or any other services that occur after the termination date of coverage under the Policy.

Care or Complications Related To Non-Covered Medical Expenses. No benefits are available for the cost of any non-Covered Medical Expenses or for the cost of any care related to, resulting from, arising from or provided in connection with non-Covered Medical Expenses or for complications arising from non-Covered Medical Expenses, except as stated in Section III- DESCRIPTION OF BENEFITS, 5, A, "Dental Services." The limitations and exclusions found in this Section and in any other portion of the Policy apply, even if the service is furnished or ordered by an Insured Person's Physician or other Physician and/or the service meets the definition of Medical Necessity. Benefits for any complications resulting from non-Covered or unauthorized services are excluded from coverage.

Chelating Agents. No benefits are available for any service, supply or treatment for which a chelating agent is used, except for providing treatment for heavy metal poisoning.

Convenience Services. No benefits are available for the cost of any service that is primarily for the convenience of an Insured Person, an Insured Person's family, or a Physician. This exclusion applies even if the service is provided while an Insured Person is ill or injured, under the care of a Physician., and even if the services are furnished, ordered or prescribed by a Physician. Non-Covered Convenience Services include telephone and television rental charges in a hospital, non-patient hospital fees, charges for holding a room while an Insured Person is temporarily away from a facility, personal comfort and personal hygiene services, linen or laundry services, the cost of 'extra' equipment or supplies that are rented or purchased primarily for convenience, late discharge charges and admission kit charges.

Cosmetic Services. No benefits are available for Cosmetic Services. The cost of care related to, resulting from, arising from or medical condition caused by or providing in connection with Cosmetic Services is not covered. No benefits are available for care furnished for complications arising from Cosmetic Services. Cosmetic Services include any care, procedure, service, equipment, supplies or medications primarily intended to change an Insured Person's appearance, to improve an Insured Person's appearance or furnished for psychiatric or psychological reasons. For example: surgery or treatments to change the texture or appearance of an Insured Person's skin are not covered. No benefits are available for surgery or treatments to change the size, shape or appearance of facial or body features (such as An Insured Person's nose, eyes, ears, cheeks, chin, chest or breasts), except for the covered surgery described in Section III- DESCRIPTION OF BENEFITS 6, G "Surgery."

Custodial Care. No benefits are available for services, supplies or charges for Custodial Care. Custodial Care is not covered, even if the services are furnished or prescribed by a Physician, under the supervision of a Physician, or even if the care is prescribed or furnished by a Physician and is beneficial to the Insured Person. Custodial Care is not covered, whether or not it is furnished in a facility (such as a Hospital, Skilled Nursing Facility or Physical Rehabilitation Facility), at home or in another residential setting. Non-covered Custodial Care includes:

- Assistance with walking, bathing, or dressing;
- Oral hygiene, ordinary skin and nail care, maintaining personal hygiene or safety;
- Transfer or positioning in bed;
- Normally self-administered medicine;
- Meal preparation;
- Feeding by utensil, tube, or gastrostomy;
- Routine maintenance of ostomies;
- Catheter care
- Suctioning;
- Using the toilet;
- Enemas;
- Preparation of special diets;
- Supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel, and
- Domiciliary care. Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because a Insured Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered under any portion of the Policy.
- Convalescent care. Convalescent care is Custodial Care that an Insured Person receives during a period of recovery from an acute illness or injury.

Disease or Injury Sustained as a Result of War or Participation in Riot or Participation in Insurrections. No benefits are available for care required to diagnose or treat any illness or injury that is a result of war, participation in a riot or participation in an insurrection.

Domiciliary Care. Domiciliary care is care provided in a residential institution or setting, treatment center, halfway house, or school because an Insured Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included. Domiciliary care is Custodial Care and is not covered under any portion of the Policy.

Educational, Instructional, Vocational Services and Developmental Disability Services. Except as stated in Section III- DESCRIPTION OF BENEFITS 2, A "Diabetes Management Programs," no benefits are available for educational or instruction programs or services. Non-Covered Medical Expenses include education evaluation, testing, classes, therapy, tutoring, counseling, programs, equipment or supplies. No benefits are available for vocational/occupational evaluations, testing, classes, therapy, counseling, programs, equipment or supplies. Except as stated in Section III- DESCRIPTION OF BENEFITS, 3, D "Early Intervention Services"," no benefits are available for services, counseling, therapy, supplies, equipment or programs for behavioral reasons or for Developmental Disabilities.

Elective Surgery or Elective Treatment

Experimental/Investigational Services. Except as stated in Section III – DESCRIPTION OF BENEFITS, 6 E "Qualified Clinical Trials," We will not pay for Experimental/Investigational Services. No benefits are available for the cost of care related to, resulting from, arising from or provided in connection with Experimental/Investigational Services. No benefits are available for care furnished for complications arising from Experimental/ Investigational Services.

A. "Experimental or Investigational Service" means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply that is Experimental or Investigational and is used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition.

   A drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental or Investigational if one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought:
   1. The service cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency and such final approval has not been granted; or
   2. The service has been determined by the FDA to be contraindicated for the specific use; or
   3. The service is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
   4. The service is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
   5. The service is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental or Investigational or otherwise indicate that the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product equipment, procedure, treatment, service, or supply is under evaluation.

B. A service that is not Experimental or Investigational based on the criteria in A (above) may still be Experimental or Investigational if:
   1. The scientific evidence is not conclusory concerning the effect of the service on health outcomes;
   2. The evidence does not demonstrate that the service improves the net health outcomes of the total population for whom the service might be proposed by producing beneficial effects that outweigh any harmful effects;
   3. The evidence does not demonstrate that the service has been shown to be as beneficial for the total population for whom the service might be proposed as any established alternatives; and
   4. The evidence does not demonstrate that the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

C. When applying the provisions of A and B (above) to the administration of benefits under this health plan, We may include one or more items from the following list which is not all inclusive:
   1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
   2. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
   3. Documents of an IRB or other similar body performing substantially the same function; or
   4. Consent document(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
   5. The written protocol(s) used by the treating Physicians, other medical professionals, or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
   6. Medical records; or
   7. The opinions of consulting Physicians and other experts in the field.

We use the terms of this subsection in reviewing services that may be Experimental/Investigational. Our medical policy reflects the standards of practice and medical interventions identified as reflecting appropriate medical practice. However, the benefits , exclusions and limitations stated in the Policy take precedence over medical policy.

An Insured Person the right to appeal Benefit determinations made by Us, including Adverse Determinations regarding Experimental/Investigational Services. For complete information about the appeal process, please see Section VII – APPEALS PROCEDURE

Foot Care, (Routine) Foot Orthotics and Corrective Shoes. No benefits are available for routine foot care. Services or supplies in connection with corns, calluses, flat feet, fallen arches, weak feet or chronic foot strain are not covered. No benefits are available for foot orthotics, inserts or support devices for the feet. Corrective shoes are not covered. Foot care related to treatment of Diabetes is covered under the Diabetes benefit and not excluded here.

Free Care. Benefits are not provided for any care if the care is furnished to You without charge or would normally be furnished to You without charge. This exclusion will also apply if the care would have been furnished to You without charge if You were not covered under the Policy or under any other health plan or other insurance.

Health Club Memberships. No benefits are available for health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.

Home Test Kits. No benefits are available for laboratory test kits for home use. These include home pregnancy tests and home HIV tests.

Hospitalization for Non-Covered Medical Expenses. No benefits are available for hospital services or any other health care service related to, arising from, the result of, caused by or provided in connection with non-Covered Medical Expenses or for complications arising from non-Covered Medical Expenses, except as stated in section 6 "Covered Medical Expenses," 5, A, "Dental Services." No benefits are available for expenses incurred

when an Insured Person chooses to remain in a Hospital or another health care facility beyond the discharge time recommended by the Insured Person's Physician.

International Students – No benefits are available for expenses incurred within the Insured Person's Home Country or country of regular domicile unless a benefit amount is shown in the Schedule of Benefits for medical Treatment received in the Home Country and 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;

Missed Appointments - Physicians and other providers may charge an Insured Person for failing to keep scheduled appointments without giving reasonable notice to the office. No benefits are provided for these charges. An Insured Person is solely responsible for the charges.

Non-Hospital Institutions - No benefits are available for care or supplies in any facility that is not specifically stated as a covered facility in the Policy. No benefits are available for care or supplies in convalescent homes or similar institutions and facilities that provide primarily custodial, maintenance or rest care. No benefits are available for care or supplies in health resorts, spas, sanitariums, sanatoriums or tuberculosis hospitals.

Non-Insured Person Biological Parents - No benefits are available for services received by the biological parent of an adopted child, unless the biological parent is an Insured Person.

Nutrition and/or Dietary Supplements. Except as provided in the Policy or as required by law, no benefits are available for nutrition and/or dietary supplements. This exclusion includes those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written prescription or dispensing by a licensed pharmacist. Please see Section III- DESCRIPTION OF BENEFITS, 4, E "Durable Medical Equipment, Medical Supplies and Prosthetics," for information about benefits for some of these items.

Premarital Laboratory Work. Premarital laboratory work required by any state or local law is not covered.

Private Duty Nurses. Benefits are not provided for private duty nurses.

Processing Fees. No benefits are available for the cost of obtaining medical records or other documents that Our administrator or We consider necessary to administer benefits under the Policy.

Rehabilitation Services. No benefits are available for rehabilitation services primarily intended to improve the level of physical functioning for enhancement of job, athletic, or recreational performance. No benefits are available for programs such as, but not limited to, work hardening programs and programs for general physical conditioning.

Reversal of Voluntary Sterilization. No benefits are available for services to reverse voluntarily induced sterility.

Sclerotherapy for Varicose Veins and Treatment of Spider Veins. Except when treatment is Medically Necessary, no benefits are available for sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy. Treatment of telangiectatic dermal veins (spider veins) by sclerotherapy or any other method is not covered under any portion of the Policy because such treatment is considered to be cosmetic and not Medically Necessary.

Services Not Covered and Care Related to Non-Covered Medical Expenses. No benefits are available for services that are not specifically described as Covered Medical Expenses in the Policy. No benefits are available for services that are not covered due to a limitation or exclusion stated in the Policy. This exclusion applies even if the service meets The definition of Medical Necessity and it applies even if a Physician furnishes or orders the service. No benefits are available for care related to, resulting from, arising from, caused by or provided in connection with non-Covered Medical Expenses or for complications arising from non-Covered Medical Expenses. Examples of non-Covered Medical Expenses are:

1. Services furnished by any individual or entity that is not a Physician or as otherwise covered under the Policy;
2. Services received by someone other than the patient, except as stated in section 6 "Covered Medical Expenses," D "Organ and Tissue Transplants;"
3. A separate fee for the services of interns, nurses, residents, fellows, Physicians or other Physicians such as hospital-based ambulance services that are salaried or otherwise compensated by a hospital or other facility;
4. The travel time and related expenses of a Physician;
5. A Physician's charge to file a claim or to transcribe or duplicate An Insured Person's medical records;
6. Fees, postage, taxes or other charges for the shipping or handling of covered equipment or services; and
7. Non-legend or "over-the-counter" drugs, medications, vitamins, minerals, supplements, supplies or devices.

Surrogate Parenting. No benefits are available for services or supplies provided to a person not covered under the Policy in connection with a surrogate pregnancy (including the bearing of a child by another woman for an infertile couple.

Transportation. No benefits are available for transportation costs, except as described in Section III- DESCRIPTION OF BENEFITS, 2, "Ambulance Services".

Workers' Compensation - The Policy does not provide benefits for any condition, disease, or injury that arises out of or in the course of employment when an Insured Person is covered by Workers' Compensation, unless An Insured Person waived coverage in accordance with state law.

X-rays. No benefits are available for diagnostic x-rays in connection with research or study, except as explained for Routine Patient Care costs in Section III- DESCRIPTION OF BENEFITS, 6, E "Qualified Clinical Trials: Routine Patient Care." No benefits are available for orthopantagrams.

SECTION V – 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.

Time of Payment: If We deny or pend the claim, We shall have 15 calendar days upon receipt of an Electronic Claim or 30 days upon receipt of a non-electronic claim to notify the health care provider or Insured Person of the reason for denying or pending the claim and what, if any, additional information is required to adjudicate the claim. Upon Our receipt of the requested additional information, We shall adjudicate the claim within 45 calendar days. If the required notice is not provided, the claim shall be treated as a Clean Claim and shall be adjudicated within the 15 calendar days for Electronic Claim or 30 calendar days for a non-electronic claim. Payment of a claim shall be considered to be made on the date a check was issued or electronically transferred. We shall mail checks no later than 5 business days after the date a check was issued.

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 VI – COORDINATION OF BENEFITS

Notice to Insured Persons. If you are covered by more than one health benefit plan, you should file all your claims with each plan.

COORDINATION OF THE POLICY'S BENEFITS WITH OTHER BENEFITS

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

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

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.
   (1) Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

D. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable

expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable expense. The following are examples of expenses that are not Allowable expenses:

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

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

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

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

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

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

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

i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

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

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

i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

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

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

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

SECTION VII – APPEALS PROCEDURE

For purposes of this Section, the following definitions apply:

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

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

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

Internal Review Procedure

1. In the event of an Adverse Determination, We will notify the Insured Person immediately in writing of Our decision and the reason for the Adverse Determination. The notice will include a description of any additional information that might be necessary for reconsideration of the claim and the notice will also describe the right to appeal. The Insured Person also had the right to contact the Commissioner of Insurance or his or her office at any time. Department of Insurance Contact Information: New Hampshire Department of Insurance, 21 South Fruit Street, Suite 14, Concord,NH 03301; Toll Free Number (800)-852-3416.
2. A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. The Insured Person does not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative may:

a. review all documents related to the claim and submit written comments and issues related to the denial; and
b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

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

After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 30 days for a Prospective Review request or 60 days for a Retrospective Review request after receipt of the notice requesting the first level review.

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

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

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

Expedited reviews of grievances involving an Adverse Determination

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

If the Insured Person Disagrees with Our Internal Review Determination

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

a. File a complaint with the New Hampshire Department of Insurance, 21 South Fruit Street, Suite 14, Concord, NH 03301, (800) 852-3416 and www.nh.gov/insurance; or
b. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

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

External Review Procedure

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 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 that 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 180 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 one hundred-eighty (180) 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.

Serviced By:

Gallagher Student Health & Special Risk
500 Victory Road • Quincy, MA 02171
1-833-255-0741
Website: www.gallagherstudent.com/saintanselm

NATIONAL GUARDIAN LIFE INSURANCE COMPANY
PATIENTS' BILL OF RIGHTS
(NH RSA 151:21)

The policy describing the rights and responsibilities of each patient admitted to the facility shall include, as a minimum, the following:

I. The patient shall be treated with consideration, respect, and full recognition of the patient's dignity and individuality, including privacy in treatment and personal care and including being informed of the name, licensure status, and staff position of all those with whom the patient has contact, pursuant to RSA 151:3-b.

II. The patient shall be fully informed of a patient's rights and responsibilities and of all procedures governing patient conduct and responsibilities. This information must be provided orally and in writing before or at admission, except for emergency admissions. Receipt of the information must be acknowledged by the patient in writing. When a patient lacks the capacity to make informed judgments the signing must be by the person legally responsible for the patient.

III. The patient shall be fully informed in writing in language that the patient can understand, before or at the time of admission and as necessary during the patient's stay, of the facility's basic per diem rate and of those services included and not included in the basic per diem rate. A statement of services that are not normally covered by medicare or medicaid shall also be included in this disclosure.

IV. The patient shall be fully informed by a health care provider of his or her medical condition, health care needs, and diagnostic test results, including the manner by which such results will be provided and the expected time interval between testing and receiving results, unless medically inadvisable and so documented in the medical record, and shall be given the opportunity to participate in the planning of his or her total care and medical treatment, to refuse treatment, and to be involved in experimental research upon the patient's written consent only. For the purposes of this paragraph "health care provider'' means any person, corporation, facility, or institution either licensed by this state or otherwise lawfully providing health care services, including, but not limited to, a physician, hospital or other health care facility, dentist, nurse, optometrist, podiatrist, physical therapist, or psychologist, and any officer, employee, or agent of such provider acting in the course and scope of employment or agency related to or supportive of health care services.

V. The patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for the patient's welfare or that of other patients, if the facility ceases to operate, or for nonpayment for the patient's stay, except as prohibited by Title XVIII or XIX of the Social Security Act. No patient shall be involuntarily discharged from a facility because the patient becomes eligible for Medicaid as a source of payment.

VI. The patient shall be encouraged and assisted throughout the patient's stay to exercise the patient's rights as a patient and citizen. The patient may voice grievances and recommend changes in policies and services to facility staff or outside representatives free from restraint, interference, coercion, discrimination, or reprisal.

VII. The patient shall be permitted to manage the patient's personal financial affairs. If the patient authorizes the facility in writing to assist in this management and the facility so consents, the assistance shall be carried out in accordance with the patient's rights under this subdivision and in conformance with state law and rules.

VIII. The patient shall be free from emotional, psychological, sexual and physical abuse and from exploitation, neglect, corporal punishment and involuntary seclusion.

IX. The patient shall be free from chemical and physical restraints except when they are authorized in writing by a physician for a specific and limited time necessary to protect the patient or others from injury. In an emergency, restraints may be authorized by the designated professional staff member in order to protect the patient or others from injury. The staff member must promptly report such action to the physician and document same in the medical records.

X. The patient shall be ensured confidential treatment of all information contained in the patient's personal and clinical record, including that stored in an automatic data bank, and the patient's written consent shall be required for the release of information to anyone not otherwise authorized by law to receive it. Medical information contained in the medical records at any facility licensed under this chapter shall be deemed to be the property of the patient. The patient shall be entitled to a copy of such records upon request. The charge for the copying of a patient's medical records shall not exceed $15 for the first 30 pages or $.50 per page, whichever is greater; provided, that copies of filmed records such as radiograms, x-rays, and sonograms shall be copied at a reasonable cost.

XI. The patient shall not be required to perform services for the facility. Where appropriate for therapeutic or diversional purposes and agreed to by the patient, such services may be included in a plan of care and treatment.

XII. The patient shall be free to communicate with, associate with, and meet privately with anyone, including family and resident groups, unless to do so would infringe upon the rights of other patients. The patient may send and receive unopened personal mail. The patient has the right to have regular access to the unmonitored use of a telephone.

XIII. The patient shall be free to participate in activities of any social, religious, and community groups, unless to do so would infringe upon the rights of other patients.

XIV. The patient shall be free to retain and use personal clothing and possessions as space permits, provided it does not infringe on the rights of other patients.

XV. The patient shall be entitled to privacy for visits and, if married, to share a room with his or her spouse if both are patients in the same facility and where both patients consent, unless it is medically contraindicated and so documented by a physician. The patient has the right to reside and receive services in the facility with reasonable accommodation of individual needs and preferences, including choice of room and roommate, except when the health and safety of the individual or other patients would be endangered.

XVI. The patient shall not be denied appropriate care on the basis of race, religion, color, national origin, sex, age, disability, marital status, or source of payment, nor shall any such care be denied on account of the patient's sexual orientation.

XVII. The patient shall be entitled to be treated by the patient's physician of choice, subject to reasonable rules and regulations of the facility regarding the facility's credentialing process.

XVIII. The patient shall be entitled to have the patient's parents, if a minor, or spouse, or next of kin, or a personal representative, if an adult, visit the facility, without restriction, if the patient is considered terminally ill by the physician responsible for the patient's care.

XIX. The patient shall be entitled to receive representatives of approved organizations as provided in RSA 151:28.

XX. The patient shall not be denied admission to the facility based on medicaid as a source of payment when there is an available space in the facility.

XXI. Subject to the terms and conditions of the patient's insurance plan, the patient shall have access to any provider in his or her insurance plan network and referral to a provider or facility within such network shall not be unreasonably withheld pursuant to RSA 420-J:8, XIV.

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

Administered by:
National Guardian Life Insurance Company
Student Insurance Division
Commercial Travelers Building
70 Genessee Street
Utica, NY 13502
1-800-756-3702 – www.studentplanscenter.com

For a copy of the Company's privacy notice you may:
go to
www.studentplanscenter.com/privacy/nglic
or
Request one from the Health office at your school
or
Request one from:
National Guardian Life Insurance Company
Student Insurance Division
c/o Privacy Officer
Commercial Travelers Building
70 Genessee 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. This requirement for creditable coverage ends on December 31, 2014.

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.

National Guardian Life Insurance Company

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

AMENDMENT TO POLICY AND CERTIFICATE

The Policy, form number NBH-280 (2016) NH and Certificate, form number NBHCert-280 (2016) NH, to which this amendment is attached are amended as described below:

- The maximum age limit in item 4.a. of the Dental Services benefit is changed from age 6 years to age 13 years.
- Item 2 under Prescription Drugs is deleted in its entirety. It is replaced with the text below:
  2. Prescription and over-the-counter contraceptive drugs or devices.
- The following benefits are added to the **Prescription Drugs** benefit:
  4. For the purpose of synchronization of Prescription Drug in the treatment of chronic condition, We will apply prorated daily cost-sharing to a covered Prescription Drug such drug is dispensed by an in-network pharmacy for a less than 30-day supply. The Physician and pharmacist must determine the quantity is in the best interest of the Insured Person for the management the chronic, long term condition. The Insured Person must request or agree to the synchronization of the medications. The maintenance Prescription Drug(s) to be synchronized must meet the following requirements:
     a. The Prescription Drug must be a covered drug;
     b. The drug must be used for management and care of a chronic, long-term condition and have authorized refills that remain available to the Insured Person;
     c. The Prescription Drug is not a controlled substance included in schedules II through V, as designated by the United States Drug Enforcement Administration;
     d. The Prescription Drug meets all utilization management requirements specific to maintenance-Prescription Drugs at the time of the synchronization request.
     e. The Prescription Drugs can be effectively split over required short-fill periods to successfully synchronize the drugs; and
     f. The Prescription Drugs do not have quantity limits or dose optimization criteria which will be violated when synchronizing the Insured Person's multiple, maintenance Prescription Drugs.

     We will only apply the prorated cost-sharing to maintenance Prescription Drugs. The synchronization may only occur once per Policy Year per maintenance Prescription Drug.

  5. Prescription Eye Drops - Benefits are available for early refills for prescription eye drops as described below.
     a. For a 30-day supply, the Insured Person requests the refill no earlier than 21 days after the later of the following:
        (1) The date the original prescription was dispensed to the Insured Person; or
        (2) The date the most recent refill was dispensed to the Insured Person.
     b. For a 90-day supply, no earlier than 63 days from the later of the following:
        (1) The date the original prescription was dispensed to the Insured Person; or
        (2) The date the most recent refill of the prescription was dispensed to the Insured Person.
     c. The original prescription includes authorization for a specific number of refills.
     d. The Insured Person's request for the refill does not exceed the number of refills indicated on the original prescription.
     e. The prescription has not been refilled more than once during the 30-day or 90-day period prior to the request for an early refill.

This Amendment is effective on the Policy effective date or the Certificate effective date. There are no other changes to the Policy or Certificate.

In witness whereof, We have caused this Amendment to be signed by our President and Secretary.

Kimberly A. Shaul, Secretary

Knut A. Olson, President

Claim Procedure

In the event of Accident or Sickness the student should:

1. If at school, report immediately to the Student Health Services so that proper treatment can be prescribed.
2. If away from the School, consult a doctor and follow his advice.
3. Notify Student Health Services or the Program Administrator within 30 days after the date of the covered illness or as soon thereafter as is reasonably possible.
4. Written proof of loss (itemized bills) must be furnished with your claim within 90 days after the date of the Loss.
5. Claim forms can be obtained from the Student Health Services, or on-line from Gallagher Student Health & Special Risk at:

www.gallagherstudent.com/saintanselm

Submit the completed claim form, together with copies of itemized bills and your other insurance carrier's Explanation of Benefits, within 90 days after first treatment to National Guardian Life Insurance Company. (The address is on the claim form.)

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.

Gallagher Student Health Complements

Exclusively from Gallagher Student Health & Special Risk, enrolled students have access to the following menu of products at no additional cost. These plans are not considered insurance products and are not part of the Plan underwritten by National Guardian Life Insurance Company. More information is available at www.gallagherstudent.com.

EyeMed Vision Care

EyeMed Vision Care offers discounts on vision benefits. EyeMed's provider network gives students access to over 45,000 independent providers and retail stores nationwide, including Lens Crafters, Sears Optical, Target Optical, JC Penney Optical and most Pearle Vision locations. Students will receive a separate EyeMed ID card. There is no waiting period; students can take advantage of the savings immediately upon receipt of their EyeMed ID card. Students can expect 15% to 45% off regular retail pricing on prescription eyeglasses, conventional contact lenses or even non-prescription sunglasses, and even 5% to 15% off laser correction surgery at some of the nation's most highly qualified laser correction surgeons.

Call 1-866-8EYEMED or go online to www.eyemedvisioncare.com and choose the Access network from the drop down network option.

Basix Dental Savings

Maintaining good health extends to taking care of your teeth, gums and mouth. The Basix Dental Savings Program provides you with a wide range of dental discount services. Basix contracts with dentists that agree to charge a negotiated fee to students covered under the Gallagher Student Health Insurance plan. Students must pay for the services received at the time of service to receive the negotiated rate. Savings vary but can be as high as 50% depending on the type of service received and the contracted dentist providing the service. To use the program, students must:

- Make an appointment with a contracted dentist. Contracted dentists and their fee schedules are listed on www.basixstudent.com.
- Tell the dental office that they have the student health insurance plan and the Basix program. Students don't need a spearate ID card for the Basix program, but will need to show their student health insurance ID card to confirm eligibility.

Full details of the program are available on www.basixstudent.com. Basix can also be reached via email from their website, or by telephone at (888) 274-9961.

SilverCloud Behavioral Health

SilverCloud is an online behavioral health platform that lets students work through cognitive behavioral therapy based modules at their own pace. The platform has a broad library of online therapy programs to support positive behavior change, overall mental wellness, and treat anxiety, stress and depression. Each module is comprised of an introductory video and quiz, psychoeducational content with examples and personal stories, interactive activities, homework suggestions and summaries. SilverCloud is available to use anytime, anyplace, on any device.

Go to gsh.silvercloudhealth.com/signup to start using SilverCloud.