UNIVERSITY OF
Redlands

Student Health Insurance Plan

designed for

University of Redlands

Redlands, CA

2017–2018

Policy Number: 2017E4A14

SCHEDULE OF BENEFITS
GOLD PLAN

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

Non-Network:
Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Network Out-of-Pocket Expense Limit, but toward the Non-Network Out-of-Pocket Expense Limit. Benefits are paid at 60% of the Usual and Reasonable charge.

Deductible: Network and Non-Network Combined $500 ($250 at SHC or with SHC Referral)

Out-of-Pocket Expense Limit:

Network Provider:	Individual	$6,350
Non-Network Provider:	N/A	

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

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

Deductible, Copayments, or Coinsurance will be applied to services as indicated in the Schedule below.

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

PREFERRED PROVIDER ORGANIZATION: First Health

BENEFITS FOR COVERED INJURY/ SICKNESS	IN-NETWORK	NON-NETWORK
Ambulatory/Outpatient Services		
Outpatient Surgery: Surgeon Services Anesthetist Assistance Surgeon Services	 80% of PPO 80% of PPO 80% of PPO	 60% of U&C 60% of U&C 60% of U&C
Outpatient Surgery Miscellaneous	80% of PPO	60% of U&C
Outpatient Facility Fee	80% of PPO	60% of U&C
Diagnostic X-ray and Therapeutic Radiologic Services	80% of PPO	60% of U&C
Laboratory Procedures (Outpatient)	80% of PPO	60% of U&C
Primary Care Visit	80% of PPO	60% of U&C
Specialists Visit	80% of PPO	60% of U&C
Other Practitioner Office Visit	80% of PPO	60% of U&C
Outpatient Physician's Visit	80% of PPO	60% of U&C
Second Opinion Benefit	80% of PPO	60% of U&C
EMERGENCY SERVICE	**IN-NETWORK**	**NON-NETWORK**
Emergency Service Expense	80% of PPO	80% of PPO
Urgent Care	80% of PPO	60% of U&C
Ambulance	80% of actual charges	80% of actual charges
HOSPITALIZATION - INPATIENT	**IN-NETWORK**	**NON-NETWORK**
Hospital Room & Board Expense	80% of PPO	60% of U&C
Hospital Intensive Care	80% of PPO	60% of U&C
Hospital Miscellaneous Expenses	80% of PPO	60% of U&C
Preadmission Testing	80% of PPO	60% of U&C
Physician's Visits while Confined	80% of PPO	60% of U&C
Inpatient Surgery: Surgeon Services Anesthetist Assistance Surgeon Services	 80% of PPO 80% of PPO 80% of PPO	 60% of U&C 60% of U&C 60% of U&C
Surgical Services Directly Affecting the Upper or Lower Jawbone Benefit	80% of PPO	60% of U&C
Mastectomy Benefit and Reconstructive Breast Surgery	80% of PPO	60% of U&C
Reconstructive Surgery Benefits	80% of PPO	60% of U&C
Bariatric (Weight Loss) Surgery	80% of PPO	60% of U&C
General Anesthesia for Dental Procedures	80% of PPO	60% of U&C for covered dental expenses
Organ Transplant	80% of PPO	60% of U&C
Hospice Care Coverage	80% of PPO	60% of U&C
Physical Therapy (inpatient)	80% of PPO	60% of U&C
Registered Nurse's Services	80% of PPO	60% of U&C
Skilled Nursing Facility	80% of PPO	60% of U&C

MATERNITY AND NEWBORN CARE	**IN-NETWORK**	**NON-NETWORK**
Routine Prenatal Care	100% of PPO Allowance for Preventive Services	60% of U&C
Hospital stay for mother and child	80% of PPO	60% of U&C
Inpatient Physician or Surgeon	80% of PPO	60% of U&C
Physician directed Follow-up Care	80% of PPO	60% of U&C
Maternity Pre-Natal Alpha Feto Protein Test	80% of PPO	60% of U&C
Breast Feeding Support & Supplies	100% of PPO	60% of U&C
Routine Newborn Care	80% of PPO	60% of U&C
MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER SERVICES	80% of PPO	60% of U&C
PRESCRIPTION DRUGS	**IN-NETWORK**	**NON-NETWORK**
Prescription Drugs Includes injectable drugs $250 maximum per 30 day supply	80% of actual charges for Covered Rx	80% of actual charges for Covered Rx
Family Planning	100% of actual charges for Preventive Services	60% of U&C
AIDS Vaccine	80% of actual charges	60% of actual charges for Covered Rx
REHABILITATION AND HABILITATIVE SERVICE	**IN-NETWORK**	**NON-NETWORK**
Rehabilitation Therapy (Outpatient)	80% of PPO	60% of U&C
Habilitative Service (Outpatient)	80% of PPO	60% of U&C
Behavioral Health Treatment for Pervasive Developmental Disorder or Autism	80% of PPO	60% of U&C
Home Health Care Expenses	80% of PPO	60% of U&C
Prosthetic and Orthotic Devices	80% of PPO	60% of U&C
Special Shoe Benefit	80% of PPO	60% of U&C
Contact lenses to Treat Aniridia and Aphakia	80% of PPO	60% of U&C
Durable Medical Equipment	80% of PPO	60% of U&C
LABORATORY SERVICES	**IN-NETWORK**	**NON-NETWORK**
Diagnostic Testing Service	80% of PPO	60% of U&C
Specialty Diagnostic Service	80% of PPO	60% of U&C
Breast Cancer Screening and Mammography	100% of PPO Allowance for Preventive Services	60% of U&C
Prostate Cancer Screening For male age 50 or over, one digital rectal exam and one prostate specific antigen test each Policy Year	100% of PPO Allowance for Preventive Services	60% of U&C
Colorectal Cancer Screening Benefit	100% of PPO Allowance for Preventive Services	60% of U&C
Cervical Cancer Screening	100% of PPO Allowance for Preventive Services	60% of U&C
HIV Testing	100% of PPO Allowance for Preventive Services	60% of U&C

PREVENTIVE AND WELLNESS SERVICE AND CHRONIC DISEASE MANAGEMENT	**IN-NETWORK**	**NON-NETWORK**
Preventive Services including Well-woman visits Routine vision care for Insureds over 18 Hearing and screening exams Lead screenings Allergy services	100% of PPO Allowance for Preventive Services	60% of U&C
Preventive Cancer Screening Tests	100% of PPO Allowance for Preventive Services	60% of U&C
Diabetes Benefit including Diabetic Drugs and Supplies	On the same basis as any other Covered Sickness or Rx Expense	
Osteoporosis Coverage/Bone Mass Measurement Benefit	100% of PPO Allowance for Preventive Services	60% of U&C
Diethylstilbestrol (DES) Exposure Coverage	80% of PPO	60% of U&C
Phenylketonuria (PKU) Testing and Treatment Benefit	80% of PPO	60% of U&C
Dental Services in Preparation for Radiation Therapy Benefit	80% of PPO	60% of U&C
PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE	**IN-NETWORK**	**NON-NEWORK**
Pediatric Immunizations	100% of PPO Allowance for Preventive Services	60% of U&C
Pediatric Asthma Services	80% of PPO Allowance Charge for Covered Rx Expenses	60% of U&C for Covered Rx Expenses
Comprehensive Pediatric Preventive Services	100% of PPO Allowance for Preventive Services	60% of U&C

Pediatric Dental Care Benefit Preventive Dental Care to 2 dental exams every 12 months	See Benefit for limitations 100% of PPO Allowance for Preventive Services	See Benefit for limitations 60% of Usual &Reasonable for Preventive Services
The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:	See Benefit for limitations	See Benefit for Limitations
Routine Dental Care	70% Usual & Reasonable for Covered Medical Expenses	70% Usual & Reasonable for Covered Medical Expenses
Emergency Dental	50% Usual & Reasonable for Covered Medical Expenses	50% Usual & Reasonable for Covered Medical Expenses
Endodontic Services	50% Usual & Reasonable for Covered Medical Expenses	50% Usual & Reasonable for Covered Medical Expenses
Prosthodontic Services	50% Usual & Reasonable for Covered Medical Expenses	50% Usual & Reasonable for Covered Medical Expenses
Medically Necessary Orthodontic Care	50% Usual & Reasonable for Covered Medical Expenses	50% Usual & Reasonable for Covered Medical Expenses
Pediatric Vision Care Benefit Limited to 1 visit and 1 pair of prescribed lenses and frames per Policy Year	100% of PPO Allowance for Covered Medical Expenses	60% of U&C
ADDITIONAL BENEFITS FOR COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Student Health Center/Infirmary Expense	100% of U&C for Covered Medical Expenses	
Abortion Expense	80% of PPO	60% of U&C
OTHER HEALTH BENEFITS	**IN-NETWORK**	**NON-NETWORK**
Accidental Injury Dental Treatment for Insured Person's over age 18	80% of PPO Allowance	80% of U&C
Acupuncture	80% of PPO	60% of U&C
Clinical Trials	80% of PPO	60% of U&C
Dialysis Care	80% of PPO	60% of U&C
Non-emergency transportation	80% of PPO	60% of U&C
Organ Donation Service	80% of PPO	60% of U&C
Ostomy, Urinary Supplies	80% of PPO	60% of U&C

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum for Double Dismemberment or Loss of Life..... $5,000.00
½ Principal Sum for Single Dismemberment $2,500.00

Loss must occur with 180 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one loss occurs as the result of any one Accident. This benefit is payable in addition to any other benefits payable under the Policy.

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the Administrative Agency Summit America Insurance Services, An Ascension Company, at 1-877-246-6997.

COVERAGE

1. Accident and Sickness coverage begins on August 17, 2017, or the date of enrollment in the plan, whichever is later and ends August 17, 2018.
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.

DISPUTE RESOLUTION: Should a dispute arise concerning the policy or the payment of a claim hereunder, contact us in writing at Summit America Insurance Services, An Ascension Company, PO Box 25936, Overland Park, KS 66225. If a dispute is not resolved to your satisfaction, you may contact the Consumer Services Division of the California Department of Insurance at 300 S. Spring Street, Los Angeles, CA 90013 or by phone at 1-800-927-HELP (1-800-927-4357); TDD: 800-4TDD (4833).

The following applies to Insured Persons age 65 or older only: YOU HAVE THE RIGHT TO RETURN THE CERTIFICATE, BY MAIL OR OTHER DELIVERY METHOD, WITHIN 30 DAYS OF ITS RECEIPT, AND TO HAVE THE FULL PREMIUM AND ANY POLICY OR MEMBERSHIP FEE PAID REFUNDED.

Insured Persons who have complaints regarding their ability to access needed health care in a timely manner may complain to Us and to the California Department of Insurance. Our contact information can be found on this page and the Consumer Services Division of the Department of Insurance's contact information can be found at the end of the Certificate.

Limitations to Network Provider services can be found in Section 4 Benefits.

If an Insured Person uses a Network Provider, the Policy will pay the Coinsurance percentage of the PPO Allowance shown in the Schedule of Benefits for Covered Medical Expenses. If a Non-Network Provider is used, the Policy will pay the percentage of Usual and Reasonable Covered Medical Expense shown in the Schedule of Benefits. Note, however, that We will pay the PPO Allowance level for treatment by a Non-Network Provider if: there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or the Insured Person has an Emergency Medical Condition and immediate medical treatment is needed.

CERTIFICATE OF
STUDENT GROUP HEALTH INSURANCE
issued by
NATIONAL GUARDIAN LIFE INSURANCE COMPANY, PO BOX 1191, Madison, WI
53701-1191

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

We hereby certify that the eligible student of the Policyholder is insured for:

1. Medically Necessary expenses incurred to treat a Covered Sickness or Covered Injury; and
2. Expenses incurred for covered preventive services, sustained by an Insured Person under the provisions of policy form NBH-280 (2015) CA NPPO ("the Policy").

Table of Contents

Section 1 — Definitions

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

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

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

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

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

Behavioral Health Treatment means professional services and Treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the function of an individual with pervasive developmental disorder of autism.

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

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

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

Chronic and Seriously Debilitating means diseases or conditions that require ongoing Treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

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 or scholar 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 Clinical Trials means phase I, II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:

Involve the treatment of life-threatening medical conditions,

1. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives, and
2. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives.

Covered Clinical Trials must also meet the following requirements:

1. Must involve determinations by treating Physicians, relevant scientific data, and opinions of experts in relevant
2. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.
3. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

Covered Injury means a bodily injury that is:

1. Sustained by an Insured Person while he/she is insured under the Policy or the School's prior policies; and
2. Caused by an accident directly and independently of all other causes.

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

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

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

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

Domestic Partner means two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. A domestic partnership shall be established in California when both persons file a Declaration of Domestic Partnership with the Secretary of State pursuant to this division, and, at the time of filing, all of the following requirements are met:
1. Neither person is married to someone else or is a member of another domestic partnership with someone else that has not been terminated, dissolved, or adjudged a nullity.
2. The two persons are not related by blood in a way that would prevent them from being married to each other in this state.
3. Both persons are at least 18 years of age, except as provided in Section 297.1.
4. Either of the following:
   a. Both persons are members of the same sex.
   b. One or both of the persons meet the eligibility criteria under Title II of the Social Security Act as defined in Section 402(a) of Title 42 of the United States Code for old-age insurance benefits or Title XVI of the Social Security Act as defined in Section 1381 of Title 42 of the United States Code for aged individuals.

Notwithstanding any other provision of this section, persons of opposite sexes may not constitute a domestic partnership unless one or both of the persons are over 62 years of age.

5. Both persons are capable of consenting to the domestic partnership.

Any references herein to spouse and marriage include domestic partners and domestic partnerships.

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

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

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

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

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

Emergency Services means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services through the "911" emergency response system, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

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

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Family Planning means counseling and education services are available with respect to all FDA-approved contraceptive drugs, devices, and other products for women, including those over the counter, and voluntary sterilization procedures. Family Planning also includes follow up services related to such contraceptive drugs, devices, products and procedures including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal. See Family Planning Contraceptive Methods (includes Sterilization Operations or Procedures) in the Prescription Drug benefit for more information.

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

Healthy Families Program Plan means the health benefits for pediatric oral care covered under the dental plan available to subscribers of the Healthy Families Program in 2011–2012.

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

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

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

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

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

Hospital 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.

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

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

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

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

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

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

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

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

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

Non-emergency transportation means the transfer of an Insured Person in a licensed ambulance and psychiatric transport van service when the vehicle transports the Insured Person to or from covered services and the use of other means of transportation may endanger the insured's health. This includes the transfer of an Insured Person from one Hospital to another Hospital or facility (includes mental health facilities) to home when the transportation is:

1. Medically necessary, and
2. Requested by a plan provider, and
3. Authorized in advance by the participating health plan.

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

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

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

Physician means a:

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

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

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

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

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

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

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

Prosthetic Devices (excluding dental) means artificial limb devices or appliances designed to replace in whole or in part an arm or a leg. Benefits for Prosthetic Devices include coverage of devices that replace all or part of a permanently inoperative or malfunctioning internal or external organ, and are furnished on a Physician's order. This benefit also covers prosthetic devices for post laryngectomy. Examples of Prosthetic Devices include but are not limited to artificial limbs, cardiac pacemakers, prosthetic lenses, breast prosthesis (including mastectomy bras), and maxillofacial devices.

Qualified Autism Service Paraprofessional means an unlicensed and uncertified individual who meets all of the following criteria:
1. Is employed and supervised by a Qualified Autism Service Provider.
2. Provides Treatment and implements services pursuant to a Treatment plan developed and approved by the Qualified Autism Service Provider.
3. Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.
4. Has adequate education, training and experience, as certified by a Qualified Autism Service Provider.

Qualified Autism Service Professional means an individual who meets all of the following criteria:
1. Provides Behavioral Health Treatment.
2. Is employed and supervised by a Qualified Autism Service Provider.
3. Provides Treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider.
4. Is a behavioral service provider approved as a vendor by a California regional center to provide services as an associate behavior analyst, behavior management assistant, behavior management consultant, or behavior management program as defined in Section 54342 of Title 17 of the California Code of Regulations.
5. Has training and experience in providing services for pervasive development disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

Qualified Autism Service Provider means a person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity, or group that is nationally certified.

Reconstructive Breast Surgery means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts, and includes reconstruction of the mastectomy site, creation of a new breast mound, and creation of a new nipple/areolar complex. Reconstructive breast surgery also includes augmentation mammoplasty, reduction mammoplasty, and mastopexy of the non-diseased breast.

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

Rehabilitation Services means treatment, services and supplies for the purpose of restoring bodily function, which has been lost due to either an Injury or Sickness. Care ceases to be Rehabilitative Services when either (i) the Insured Person can perform the activities which are normal for the same age and gender; or (ii) the Insured Person has reached the maximum therapeutic benefit and further Rehabilitative Services cannot restore further bodily function beyond the level the Insured Person currently possesses.

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

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

Serious Emotional Disturbances of a Child means a child who:
1. Has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms, and
2. Who meets the criteria in paragraph (2) of the subdivision (a) of Section 5600.3 of the Welfare and Institutions Code.

Severe Mental Illnesses includes schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.

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

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

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

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

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

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

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

Temporomandibular Disorder(s) means a group of musculoskeletal conditions, often overlapping, that involve the temporomandibular joint (TMJ) or joints, the masticatory musculature, or both. These conditions are typically characterized by pain in the preauricular area which is usually aggravated by chewing or jaw function, and are frequently accompanied, either singly or in combination, by limitation of jaw movement, joint sounds, palpable muscle tenderness or joint soreness. Although pain and dysfunction in the orofacial or craniofacial regions have multiple sources and etiologies that may coexist with temporomandibular disorders or show signs similar to those of temporomandibular disorders; temporomandibular disorders are limited to pain and dysfunction arising in and from the masticatory musculoskeletal system

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

Usual and Reasonable 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.

Section 2 – Eligibility, Enrollment and Termination

All full-time undergraduate students (9 credit hours or more) who are registered and attending classes at the University are eligible on a waiver participation basis. Graduate assistants in the athletic department (GMIs) are enrolled through the athletic department.

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

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

Extension of Benefits: Coverage under the Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows:

1) If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to 90 days from the Termination Date while such confinement continues.

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

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

Section 3 – Student Health Center Referral

This is a supplemental plan. Where available, the student must first use the resources of the Student Health Center (SHC) where treatment will be administered or a referral issued. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary ONLY under the following conditions:
1. For an Emergency Medical Condition. The student must return to the SHC for necessary follow-up care;
2. When the SHC is closed;
3. For medical care obtained when a student is no longer able to use the SHC due to a change in student status.
4. For obstetrical and gynecological care;

5. When service is rendered at another facility during break or vacation period;
6. For psychotherapy or psychological services;
7. For Preventive Services;
8. For Pharmacy Services.

Section 4— BENEFITS

Benefit Payment for Network Providers and Non-Network Providers - The Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. The Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

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

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

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

1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. the Insured Person has an Emergency Medical Condition and immediate medical treatment is needed. This benefit will continue to be paid for the Emergency Services until the Insured Person is Stabilized and can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.

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

Preventive Services

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

1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved.
3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.
5. Additional state mandated preventive services including:
   - Reasonable health appraisal examinations on a periodic basis (i.e. routine physical maintenance examinations);
   - Preventive vision screening for all ages;
   - Hearing examination to determine the need for hearing correction (diagnostic audiometry) for all ages; and
   - Health education counseling and programs for stress management and chronic conditions including diabetes and asthma;
   - Screening for tobacco use and, for Insured Persons currently using tobacco products, at least 2 tobacco cessation attempts per Policy Year. Covering a cessation attempt includes coverage for:
     - 4 tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling, or individual counseling); and
     - All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Physician.

Essential Health Benefits

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

Treatment of Covered Injury or Covered Sickness:

We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to Covered Injury or Covered Sickness. Benefits payable are subject to:

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

The following are shown in the Schedule of Benefits:

- Deductible
- Any specified benefit maximums for other than Essential Health Benefits
- 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.

Out-of-Pocket Expense Limit

The Out-of-Pocket Expense Limit is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. If the Insured Person uses a Network Provider, any Coinsurance, Deductible, or Copayment will be included in the Network Out-of-Pocket Expense Limit. If the Insured Person uses a Non-Network Provider, any Coinsurance, Deductible, or Copayment will be included in the Non-Network Out-of-Pocket Expense Limit. However, any Coinsurance, Deductible, or Copayment for Non-Network emergency care will be included in the Network Out-of-Pocket Expense Limit.

Basic Injury and Sickness Benefit

If:

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

Payment will be made, Subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits:

1. For the Usual and Reasonable Charges for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

Covered Medical Expenses

We will pay the Usual and Reasonable charges incurred for Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness. The Covered Medical Expenses for an issued Policy will be only those listed below and as shown in the Schedule of Benefits.

PREFERRED PROVIDER ORGANIZATION:

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

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

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

1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. the Insured Person has an Emergency Medical Condition and immediate treatment is needed. This benefit will continue to be paid for the Emergency Services until the Insured Person is Stabilized can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.

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

To locate a First Health Provider in Your area, consult Your Provider Directory or call toll free 800-226-5116 or visit the Network website at www.myfirsthealth.com.

ESSENTIAL HEALTH BENEFITS

Ambulatory/Outpatient Care Services Benefits as follows:

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

Outpatient Surgery Miscellaneous (excluding non-scheduled surgery) related to surgery performed in a hospital emergency room, trauma center, physician's office, outpatient surgical center or clinic. Benefits will be paid for services and supplies, including:

a. Operating room;
b. Therapeutic services;
c. Oxygen, oxygen tent;

d. Blood and blood plasma; and
e. Miscellaneous supplies.

Outpatient Facility Fee for outpatient facilities, including an ambulatory surgical center, for outpatient surgeries and procedures not including: removal of wisdom teeth whether or not imbedded in bone.

Diagnostic X-rays and Therapeutic Radiological Services for diagnostic X-ray and Therapeutic Radiological Services as shown in the Schedule of Benefits when prescribed by a physician.

Laboratory Procedures for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

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

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

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

Outpatient Physician's Visits for Physician's office visits, including visits by licensed registered nurses and licensed physician's assistants. Physician's Visit benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit. Visits are for treatment of a Covered Sickness or Covered Injury or as otherwise required as a Preventive Service.

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

EMERGENCY SERVICES

Emergency Services Expense for an Emergency Medical Condition and incurred in a Hospital emergency room, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

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

Ambulance Service for transportation to or from a Hospital by ground or air ambulance.

Hospitalization - Inpatient Benefits

Hospital Room and Board Expense including general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed. If the Insured Person's treating Physician recommends a private room that is determined to be Medically Necessary for the Covered Sickness or Covered Injury, the expense incurred will be considered a Covered Expense, subject to the terms of the Policy.

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

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

Preadmission Testing for routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital. These tests must be performed within three working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays.

Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

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

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

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

Mastectomy Benefit and Reconstructive Breast Surgery for inpatient care following a mastectomy and inpatient care following a lymph node dissection for the treatment of breast cancer. The length of Hospital stay associated with these procedures will be determined by the attending Physician and surgeon in consultation with the Insured Person, postsurgery, consistent with sound clinical principles and processes. We will also pay the expenses incurred for reconstructive breast surgery performed as a result of a partial or total mastectomy. Because breasts are a paired organ, any such reconstructive breast surgery shall include coverage for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed.

The coverage shall include coverage for all stages and revisions of Reconstructive Breast Surgery performed on a non-diseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for all complications in all stages of mastectomy, including lymphadema. Breast prostheses are covered following a mastectomy. Please refer to the Durable Medical Equipment provision for more information. Reconstruction of the nipple/areolar complex following a mastectomy is covered without regard to the lapse of time between the mastectomy and reconstruction, subject to the approval of the treating Physician.

Reconstructive Surgery Benefits for reconstructive surgery including surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

1. To improve function; and
2. To create a normal appearance, to the extent possible.
3. The definition also includes Medically Necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures.

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

Bariatric (Weight Loss) Surgery Benefit for the treatment of morbid obesity when determined to be Medically Necessary. We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Physician Services. Completion of the presurgical educational preparatory program is required before surgery is approved.

A transportation benefit is covered if Insured Person must travel more than 50 miles from facility to which patient is referred.

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

Organ Transplant for organ transplant, bone marrow transplant, or tissue transplant or replacement and includes the cost of solid organ, bone marrow, or other tissue transplantation services The only organ transplants eligible for this benefit are those that are not considered Experimental. If the Insured Person is infected with human immunodeficiency virus (HIV), eligibility for this benefit is not affected.

An Insured Person may be directed to a facility designated by Us as a Transplant Network for certain services. If the Insured Person agrees to use the Transplant Network to which We direct the Insured Person, We will provide benefits for the Insured Person's transportation to and from the Transplant Network for the initial treatment, evaluation and for the resulting confinement.

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

Hospice Care Coverage for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. The medical prognosis must be death within twelve months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

Physical Therapy while Confined for physical therapy when prescribed by the attending Physician.

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

1. Skilled Nursing Facility Expense Benefit for the services, supplies and treatments rendered to an Insured Person by a Skilled Nursing Facility for unlimited days per Policy Year. Services, supplies and treatments by a Skilled Nursing Facility include: Charges for room and board and general nursing services;
2. Charges for physical, occupational or speech therapy;
3. Charges for drugs, biologicals, supplies, appliances and equipment used in such facility which are ordinarily furnished by the Skilled Nursing Facility for the care and treatment of a confined person; and
4. Charges for medical services of interns in training, under a teaching program of a Hospital with which the facility has an agreement for such services.

MATERNITY AND NEWBORN CARE

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

1. Routine prenatal care for services received by a pregnant female in a Physician's, obstetrician's, or gynecologist's office. Coverage for prenatal care under this benefit is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check).
2. 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.
3. Inpatient Physician charges or surgeon charges will be covered the same as for any other Covered Sickness for both mother and newborn child.
4. Physician-directed Follow-up Care including:
   a. Physician assessment of the mother and newborn;
   b. Parent education;
   c. Assistance and training in breast or bottle feeding;
   d. Assessment of the home support system;
   e. Performance of any prescribed clinical tests; and
   f. Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

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

Maternity Pre-Natal Alpha Feto Protein Testing for participation in the statewide prenatal testing program administered by the State Department of Health Services known as the Expanded Alpha Feto Protein Program.

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

Routine Newborn Care for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:

1. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
2. Inpatient Physician visits for routine examinations and evaluations;
3. Charges made by a Physician in connection with a circumcision;
4. Routine laboratory tests including lead screening;
5. Post-partum home visits prescribed for a newborn;
6. Follow-up office visits for the newborn subsequent to discharge from a Hospital ; and
7. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the treatment of such newly born child.

MENTAL HEALTH DISORDER AND SUBSTANCE USE DISORDER SERVICES, including Behavioral Health Treatment

Mental Health Disorders and Substance Use Disorder benefits are processed and paid the same as any Covered Sickness. The diagnosis and all Medically Necessary treatment are covered. Mental Health Disorders include Severe Mental Illnesses of a person of any age and Serious Emotional Disturbances of a Child.

PRESCRIPTION DRUGS

Prescription Drugs 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. This includes all Medically Necessary outpatient prescription drugs. Benefits include hypodermic needles, syringes or any other disposable devices Medically Necessary required

for the administration of a prescription drug. Benefit also includes drugs for sexual dysfunction which are limited up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period per Policy Year. If the pharmacy's retail price for a drug is less than the applicable Copayment amount, the Insured Person shall not be required to pay any more than the retail price.

a. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
   1. The drug is approved by the FDA;
   2. The drug is prescribed for the treatment of a life-threatening condition or a Chronic and Seriously Debilitating condition including but not limited to cancer or human immunodeficiency virus or acquired immunodeficiency syndrome (HIV/AIDS);
   3. The drug has been recognized for treatment of that condition by one of the following:
      a) The American Medical Association Drug Evaluations;
      b) The American Hospital Formulary Service Drug Information.
      c) The United State Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or
      d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

      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 of this benefit.

   As it pertains to this benefit, life-threatening means either or both of the following:

   a) Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
   b) Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

b. Prescription contraceptive supplies ordered by a health care provider with prescriptive authority for reasons other than contraceptive purposes will be covered.
c. Benefits for non-formulary drugs will be paid on the same basis as non-preferred brand drugs. See Schedule of Benefits.

Family Planning Contraceptive Methods (includes Sterilization Operations or Procedures) for all federal Food and Drug Administration (FDA) approved prescription contraceptive drugs, devices and other products for women, including those available over the counter, voluntary sterilization procedures, patient education and counseling, and follow up services without cost-sharing. If the health care provider does not think that the method requested by Insured Person is medically appropriate for the Insured Person's medical or personal history, the insurer shall, in the alternative, provide coverage for some other FDA approved prescription contraceptive method prescribed by the patient's health care provider.

AIDS Vaccine for Acquired Immune Deficiency Syndrome. The vaccine must be recommended by the United States Public Health Service.

REHABILITATION AND HABILIATIVE SERVICES

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

Habilitative Services (Outpatient) for medically appropriate and necessary services that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Habilitative Services are provided on the same basis and under the same terms and conditions as the Rehabilitation Therapy benefit.

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism for Behavioral Health Treatment, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore to the maximum extent practicable, the functioning of An Insured Person diagnosed with the pervasive developmental disorder or autism.

The treatment must be prescribed by a licensed Physician or developed by a licensed psychologist, and must be provided under a documented treatment plan prescribed, developed and approved by a Qualified Autism Service Provider providing Treatment to the Member for whom the Treatment plan was developed. The treatment must be administered by the Qualified Autism Service Provider, or by Qualified Autism Service Professionals and Paraprofessionals who are supervised and employed by the treating Qualified Autism Service Provider.

A licensed Physician or licensed psychologist must establish the diagnosis of pervasive development disorder or autism.

Home Health Care Services for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary. We cover up to 2 hours per visit (nurse, MSW, physical/occupational/speech therapist) or three (3) hours for home health aide, up to 3 visits per day and unlimited visits per Policy Year. Home Health Care visits related to maternity care will be payable under the Maternity Benefit and not this Benefit.

Prosthetic and Orthotic Devices for Prosthetic and Orthotic Devices that are Medically Necessary to restore or maintain the ability to complete activities of daily living that replace all or part of a permanently inoperative or malfunctioning internal or external organ. The device must be furnished based on a Physician's order and not be solely for comfort or convenience. Benefits include coverage of all services and supplies Medically Necessary for the effective use of a Prosthetic or Orthotic Device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the Insured Person in the use of the device. This benefit includes coverage for prosthetic devices for post laryngectomy. Benefits also include coverage for any repair or replacement of such a Prosthetic or Orthotic Device .

Special Shoe Benefit: for special footwear as needed by Insured Persons who suffer from foot disfigurement, including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes, and foot disfigurement caused by accident or development disability

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

Special contact lenses to treat aniridia (missing iris) or aphakia, (absence of the crystalline lens of the eye) are as follows:

a. Aniridia: Up to two medically necessary contact lenses per eye (including fitting and dispensing) in any 12-month period, whether provided by the plan during the current or a previous 12-month contract period.
b. Aphakia: Up to six medically necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year for enrollees through age nine (9), whether provided by the plan under the current or a previous contract in the same calendar year.

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

Durable Medical Equipment for home use and prosthetic and orthotic devices for rental or purchase, the fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and services to determine whether the Insured Person needs a device, including, but not limited to:

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

LABORATORY SERVICES

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

Specialty Diagnostic Services for specialty diagnostic tests, and including related professional fees, incurred on an Outpatient basis. Specialty Diagnostic Tests include nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance

imaging MRI), positron emission tomography (PET), angiography, arthroscopy, cholangiography, cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatography, vasography, or venography.

Breast Cancer Screening - Mammography for Low-dose Screening Mammography. Coverage for low-dose screening mammography shall be provided as follows:

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

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

Prostate Cancer Screening: Prostate-Specific Antigen (PSA) tests or Equivalent Tests for the Presence of Prostate Cancer tests for serological tests to determine the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease. Benefit includes expenses incurred for the screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice.

Colorectal Cancer Screening Benefit for colorectal cancer examinations and laboratory tests for cancer, in accordance with the most recently published American Cancer Society guidelines or guidelines adopted by California laws and regulations for colorectal screening, for any nonsymptomatic Insured Person who is:

1. At least 50 years of age; or

2. Less than 50 years of age and at high risk for colorectal cancer according to the most recently published colorectal cancer screening guidelines of the American Cancer Society or guidelines adopted by California laws and regulations.

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

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

HIV Testing for the human immunodeficiency virus (HIV) screenings, regardless of whether the testing is related to a primary diagnosis.

PREVENTIVE AND WELLNESS SERVICES AND CHRONIC DISEASE MANAGEMENT

Preventive Services

If an Insured Person receives any other Covered Services and Supplies in addition to Preventive Care Services during the same visit, he or she will also pay the applicable Copayment or Coinsurance for those services.

Well-woman services for annual preventive physical examinations, immunizations, well-woman examinations, preventive services for pregnancy, other women's preventive services as supported by the Health Resources and Services Administration (HRSA), and preventive vision and hearing screening examinations.

Routine Vision Care for Insured Persons over 18 for routine eye exams for refraction and preventive vision screenings once every benefit year.

Hearing Screenings and Exams for expenses incurred for examinations for hearing tests, and audiological evaluations to measure the extent of hearing loss and a hearing aid evaluation.

Lead Screenings for the screening of Dependent children who are Insured Persons to determine the lead levels contained in the blood.

Allergy Services for allergy testing and allergy injections.

Preventive Cancer Screening Tests for all generally medically accepted cancer screening tests specified in the Schedule of Benefits including, but not limited to, cervical pap smear, prostate cancer screening and colorectal cancer screening.

Diabetes Benefit for medically appropriate and necessary services, including diabetes outpatient self-management training and educational services, and medical nutrition therapy necessary to enable an Insured Person to properly use the equipment, supplies, and medications used to treat diabetes. Diabetes outpatient self-management training and educational services shall be provided by a Physician or a health care professional designated by the Physician. This benefit also covers instruction that will enable the diabetic patient and their family to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to thereby avoid frequent Hospitalizations and complications. Cost sharing must not exceed that of a Physician office visit. We will cover medically necessary foot care for the treatment of diabetes when it is not palliative or cosmetic.

This benefit includes coverage for the following equipment and supplies for the treatment of diabetes (including insulin), even if the items are available without a prescription. The diabetic supplies and equipment include, but are not limited to, blood glucose monitors and testing strips; blood glucose monitors designed to assist the visually impaired; insulin pumps and all related necessary supplies; Ketone urine testing strips; lancets and lancet

puncture devices; pen delivery systems for the administration of insulin; podiatric devices to prevent or treat diabetes-related complications; insulin syringes; and visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

Osteoporosis for services related to diagnosis, treatment, and appropriate management of osteoporosis. The services may include, but need not be limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate. We will only pay for a Bone Mass Measurement every 23 months, unless a Physician determines that a more frequent measurement is Medically Necessary as follows. Conditions under which more frequent Bone Mass Measurement coverage may be Medically Necessary include, but are not limited to:

1. Monitoring beneficiaries on long-term glucocorticoid therapy of more than three months; or
2. Allowing for a central bone mass measurement to determine the effectiveness of adding an additional treatment regimen for a qualified individual who is proven to have low bone mass so long as the bone mass measurement is performed 12 to 18 months from the start date of the additional regimen.

Diethylstilbestrol (DES) Exposure Coverage for conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

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

Dental Services in Preparation for Radiation Therapy Benefit for when those services are necessary to prepare the jaw for radiation therapy of cancer in the head or neck. These services include extraction, dental evaluation, X-rays, and fluoride treatment.

PEDIATRIC SERVICES, INCLUDING ORAL AND VISION CARE

Pediatric Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

Pediatric Asthma Services for the management and treatment of pediatric asthma. Prescription Drug treatment is covered as stated in the Formulary. Inhaler spacers and peak flow meters used for the management and treatment of asthma are covered when Medically Necessary. Nebulizers (including face masks and tubing) are covered under the medical benefit under Durable Medical Equipment.

Comprehensive Pediatric Preventive Services for the comprehensive preventive care of children 17 and 18 years of age or younger consistent with the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987.

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

The following services are covered:

a. Periodic health evaluations.
b. Immunizations.
c. Laboratory services in connection with periodic health evaluations.

Pediatric Dental Care Benefit for dental care services for Insured Students and Dependent Children up to age 19.

1. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
   - Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
   - Topical fluoride application;
   - Sealants on unrestored permanent molar teeth; and
   - Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
2. Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:
   - Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
   - X-ray, full mouth x-rays at twenty-four (24) month intervals, bitewing x-rays at six (6) month intervals, or panoramic x-rays at twenty-four (24) month intervals, and other x-rays if Medically Necessary;
   - Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
   - Other routine dental surgery includes: the removal of coronal remnants, extraction of exposed roots and teeth, surgical extraction of exposed roots and teeth, and the removal of soft tissue impacted teeth;
   - In-office conscious sedation;
   - Amalgam, composite restorations and stainless steel crowns; and
   - Other restorative materials appropriate for children.

3. Emergency and urgent dental care, which includes, but is not limited to, emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
4. Endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.
5. Prosthodontic services as follows:
   - Removable complete or partial dentures, including follow- up care; and
   - Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

   Fixed bridges are Covered but limited as follows:
   - Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered Optional Dental Treatment;
   - A fixed bridge is Covered when it is necessary to replace a missing permanent anterior tooth in a person sixteen (16) years of age or older and the patient's oral health and general dental condition permits. For children under the age of sixteen (16), it is considered Optional Dental Treatment. If performed on a child under the age of sixteen (16), the Insured Person must pay the difference in cost between the fixed bridge and a space maintainer;
   - Fixed bridges used to replace missing posterior teeth are considered Optional Dental Treatment when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic;
   - Fixed bridges are Optional Dental Treatment when provided in connection with a partial denture on the same arch;
   - Replacement of an existing fixed bridge is Covered only when it cannot be made satisfactory by repair;
   - The program allows up to five (5) units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction, which is Optional Dental Treatment.
   - As used in this section, Optional Dental Treatment means a dental benefit that the Insured Person chooses to have upgraded. For example, when a filling would correct the tooth but you choose to have a full crown instead. In that case, the cost of the base benefit (e.g., the filling) is covered and the Insured Person is responsible for paying the additional cost of choosing the upgraded benefit (e.g., the crown) instead.
6. Orthodontic benefits when Medically Necessary to prevent disease and promote oral health, restore oral structures to health and function, treat emergency conditions, and treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

   Procedures include but are not limited to:
   - Rapid Palatal Expansion (RPE);
   - Placement of component parts (e.g. brackets, bands);
   - Interceptive orthodontic treatment;
   - Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
   - Removable appliance therapy; and
   - Orthodontic retention (removal of appliances, construction and placement of retainers).

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

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. Low vision exam every five (5) years, and four (4) follow-up visits in any five (5) year period. This includes low vision aids such as high-power spectacles, magnifiers, and telescopes;
   e. Determination of refractive status;
   f. Binocular distance;
   g. Tonometry tests for glaucoma;
   h. Gross visual fields and color vision testing; and
   i. Summary findings and recommendation for corrective lenses.
2. Prescription lenses or a full year's supply of contact lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic and includes treatment of Aphakia. Prescription lenses also include all lens powers (single vision, bifocal, trifocal, lenticular), fashion and gradient tinting, oversized and glass-grey #3 prescription sunglass lenses. Other optional prescription lenses include: blended segment lenses, intermediate vision lenses, plastic photosensitive lenses (Transitions ®), polarized lenses, premium anti-reflective coating, ultra anti-reflective coating, hi-index lenses, polycarbonate lenses, scratch resistant coating, standard anti-reflective coatings, UV protection and tint, photochromic lenses, standard progressive lenses, and premium progressive lenses. We cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new frames more frequently, as evidenced by appropriate documentation. We also cover charges for contact lens evaluation, fitting, and follow-up care (separate from the routine eye exam). Contact lenses will be covered in lieu of other eyewear whenever they are Medically Necessary. In general, contact lenses may be Medically Necessary

and appropriate when the use of contact lenses, in lieu of eyeglasses, will result in significantly better visual and/or improved binocular function, including avoidance of diplopia or suppression. Contact lenses may be determined to be Medically Necessary in the Treatment of the following conditions, but not limited to: Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism.

ADDITIONAL BENEFITS FOR COVERED INJURY/SICKNESS

Student Health Center/Infirmary Expense Benefit - If an Insured Student incurs expenses as the result of treatment at a Student Health Center/ Infirmary, We will pay the expenses incurred. Benefits will not to exceed the amount shown in the Schedule of Benefits.

Abortion Expense: We will pay the charges for the expense of a voluntary, non-therapeutic, abortion. This benefit will be in lieu of all other Policy benefits and may not exceed the benefit shown in the Schedule of Benefits.

OTHER HEALTH BENEFITS

Accidental Injury Dental for treatment as the result of Injury. Routine dental care and treatment are not payable under this benefit. Benefits not to exceed the amount shown in the Schedule of Benefits.

Acupuncture services include all Medically Necessary acupuncture. The services that are typically provided are for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain provided that the condition may be appropriately treated by a qualified Acupuncturist in accordance with professionally recognized standards of practice and is part of a comprehensive pain management program.

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

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

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

Dialysis Care for Medically Necessary treatment of kidney disease or failure.

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

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

Organ Donation Services for actual or potential living donors, in addition to transplant services of organs, tissue, or bone marrow required as follows:

a. Coverage for donation-related services for a living donor, or an individual identified by the plan as a potential donor, whether or not the donor is an enrollee.
b. Services must be directly related to a covered transplant for the enrollee, which shall include services harvesting the organ, blood evaluations and transfusions.
c. Donor is covered for up to 90 days following the harvest and evaluation services.

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

Ostomy, Urinary Supplies for Medically Necessary ostomy and urinary supplies for treatment of a Covered Injury or Sickness. Ostomy and urological supplies include, but are not limited to the following:

Adhesives, catheter supplies skin wash, bedside drainage bag bottles, incontinence supplies for hospice patients, disposable under pads and adult incontinence garments and all other supplies and devices to comply with Physician's orders. This benefit does not include supplies that are comfort, convenience, or luxury equipment or features.

Accidental Death and Dismemberment Benefit

Principal Sum: $5,000.00

If, as the result of a covered Accident, an Insured Person sustains any of the following losses within the time shown in the Schedule of Benefits, We will pay the benefit shown.

Loss of Life	The Principal Sum
Loss of hand	One-Half the Principal Sum
Loss of Foot	One-Half the Principal Sum
Loss of either one hand, one foot or sight of one eye	One-half the Principal Sum
Loss of more than one of the above losses due to one Accident	The Principal Sum

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The principal sum is the largest amount payable under this benefit for all losses resulting from any one Accident.

Section 5 – Exclusions and Limitations

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

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

- routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
- medical services rendered by a provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
- dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person's Sound, Natural Teeth or as specifically covered in the Policy under Laboratory Services, Hospitalization – Inpatient Services, Dental Services in Preparation for Radiation Therapy, or Pediatric Dental.
- professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
- services or supplies hearing aids, except those resulting from a covered accidental Injury or as specifically covered under the Policy.
- weak, strained or flat feet, corns, calluses or ingrown toenails.
- diagnostic or surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
- treatment or removal of nonmalignant moles, warts, boils, actinic or seborrheic keratosis, dermatofibrosis or nevus of any description or form, hallus valgus repair, varicosity, or sleep disorders including the testing for same.
- charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
- any expenses in excess of Usual and Reasonable charges.
- treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
- services that are duplicated when provided by both a certified nurse-midwife and a Physician.
- expenses incurred during a Hospital emergency room visit which is not of an emergency nature.
- expenses incurred after:
  - The date insurance terminates as to the Insured Person; and
  - The Maximum Benefit for each Covered Injury or Covered Sickness has been attained.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
- charges incurred for massage, in any form, except to the extent provided in the Schedule of Benefits.
- expenses for weight increase or reduction except Medically Necessary bariatric surgery, and hair growth or removal unless otherwise specifically covered under the policy.
- expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a Covered Injury or as specifically covered under the Policy.
- expenses incurred for Plastic or Cosmetic Surgery, unless needed to repair conditions resulting from an accidental injury or for the improvement of the physiological functioning of a malformed body member, except for services related to orthognathic surgery, osteotomy or any other form of oral surgery, dentistry, or dental processed to the teeth and surrounding tissue.
  - For the purposes of this provision, Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance) In no event will any care and services for breast reconstruction or implantation or removal of breast prostheses be covered unless such care and services are performed solely and directly as a result of a Medically Necessary mastectomy.
- treatment to the teeth, including surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Policy definition of same. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits or to services specifically covered under the Policy.
- an Insured Person's:
  - committing or attempting to commit a felony, or
  - being engaged in an illegal occupation

- custodial care service and supplies.
- expenses that are not recommended and approved by a Physician.
- Respite care, day care, recreational care, residential treatment, social services, custodial care or education services of any kind do not qualify as habilitative services.

Third Party Refund – When an Insured Person is injured through the negligent act or omission of another person (the "third party"); and benefits are paid under the Policy as a result of that Injury, We are entitled to a refund by the Insured Person of all Policy benefits paid as a result of the Injury.

The refund must be made to the extent that the Insured Person receives payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment but it shall not exceed the sum of the reasonable costs actually paid by Us pursuant to the Policy to any treating medical provider. The Insured Person must complete and return the required forms to Us upon request.

If the Insured Person engaged an attorney, then the lien may not exceed the lesser of the following amounts:
1. The maximum amount determined pursuant to the rule above (for noncapitated payments).
2. One-third of the moneys due to the Insured Person under any final judgment, compromise, or settlement agreement.

If the Insured Person did not engage an attorney, then the lien may not exceed the lesser of the following amounts:
1. The maximum amount determined pursuant to the rule above (for noncapitated payments).
2. One-half of the moneys due to the Insured Person under any final judgment, compromise, or settlement agreement.

Section 6 – Claim Procedure

1. If your provider files the claim on your behalf:
   a) The claims administrator still requires certain information from you. You will need to fill out a form indicating whether or not you have other insurance coverage. You will only need to do this once per academic year. You can find the *Other Insurance Information form* in the claims section on our website at www.4studenthealth.com/redlands.
   b) Send your SHC referral form (be sure to include your name and student ID) to the claims administrator at the following address:
      Summit America Insurance Services, Inc.
      P.O. Box 25936
      Overland Park, KS 66225
   c) You will receive an Explanation of Benefits that outlines what the insurance company paid and what is your responsibility to pay, if applicable.
   d) The claims administrator will contact you if they need other information; otherwise, they will pay the claim as indicated on the EOB. Do not ignore calls or letters from the claims administrator, as this may delay payment of your claim.
   e) If you have any questions about your claim, contact Summit America Insurance Services, Inc., an Ascension Company, at (877) 246-6997, Monday–Friday, 8:30 a.m. to 5:00 p.m. Central
2. If the provider does not file a claim directly with the insurance company on your behalf, you will need to submit a claim for reimbursement for the portion of the charges the company is responsible for paying by completing these steps:
   a) Download a claim form from www.4studenthealth.com/redlands and fill it out completely.
   b) Include your policy number (as shown on your ID card) on the claim form.
   c) Attach the health center referral form.
   d) Attach bills for medicines, X-rays, laboratory charges, etc.
   e) Send your claim form, referral form (if applicable), and all bills pertaining to this claim to Summit America Insurance Services, Inc., an Ascension Company, at the address below. Try to have all itemized bills attached to the same claim form.
      Summit America Insurance Services, Inc.
      P.O. Box 25936
      Overland Park, KS 66225
   f) If you have questions about the status of your claim after it has been submitted, please call Summit America Insurance Services, Inc., an Ascension Company, at (877) 246-6997, Monday–Friday, 8:30 a.m. to 5:00 p.m. Central.
3. For prescription drug claims:
   a) If you have to pay for your prescription in full at the time of pickup, complete a Prescription Drug Claim Form, which you can download from www.4studenthealth.com/redlands (Use Your Insurance section).
   b) Mail the claim form, along with a copy of the full prescription drug receipt (not the cash register receipt) to the claims administrator at the address below:
      Summit America Insurance Services, Inc.
      P.O. Box 25936
      Overland Park, KS 66225
      The completed claim, including all Hospital and medical bills, must be submitted for payment within 90 days after the date loss occurs, or as soon thereafter as is reasonably possible. You have the right to request an independent medical review if health care services have been improperly denied, modified, or delayed based on Medical Necessity.

      Always keep a copy of all documents submitted for claims.

Section 7 – General Policy Provisions

Notice of Claim: Written notice of claim must be given to Our designated agent or Us within 20 days after the occurrence or commencement of any loss covered by the policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Us at P.O. Box 25936, Overland Park, KS 66225, or to any authorized agent of Ours, with information sufficient to identify the Insured Person shall be deemed notice to Us.

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

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

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

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

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

If any indemnity of the Policy shall be payable to the estate of the Insured Person, or to an Insured Person or beneficiary who is a minor or otherwise not competent to give a valid release, the insurer may pay such indemnity up to an amount not exceeding $1,000 to any relative by blood or connection by marriage of the insured employee or beneficiary who is deemed by the insurer to be equitably entitled thereto. Any payment made by the insurer in good faith pursuant to this provision shall fully discharge the insurer to the extent of such payment.

Subject to any written direction of the Insured Person in an application or otherwise all or a portion of any indemnities provided by the Policy on account of hospital, nursing, medical or surgical service may, at the insurer's option, and unless the Insured Person requests otherwise in writing not later than the time for filing proof of such loss, be paid directly to the hospital or person rendering such services, but it is not required that the service be rendered by a particular hospital or person.

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

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

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

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

Section 8 – Coordination of Benefits

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

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

Definitions

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

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

   (2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of

long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

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

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.
When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable expense.
The following are examples of expenses that are not Allowable expenses:
(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.
(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.
(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.
(4) If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.
(5) The amount of any benefit reduction by the Primary plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

Order of Benefit Determination Rules

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

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

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policy holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

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

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

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

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

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

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

However, if one spouse's 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 and the parent with the custody of the dependent child has remarriedor 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 or Domestic Partner of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse or Domestic Partner 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 Benefit 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 Us 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.[2]

Section 9 – Appeals Procedure

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

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. California Department of Insurance, Health Claims Bureau, IMR Unit, 300 S. Spring St., 11th Floor, Los Angeles, CA 90013.
2. A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. The Insured Person does not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative may:
   a. review all documents related to the claim and submit written comments and issues related to the denial; and
   b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

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

   After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 15 days for a Prospective Review request or 30 days for a Retrospective Review request after receipt of the notice requesting the first level review.

   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.
3. A concurrent review is available if the Insured Person requests to extend a course of Treatment beyond time/number of Treatments, and notification of determination is required within 24 hours of the claim.

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 California Department of Insurance, Health Claims Bureau, IMR Unit, 300 S. Spring St., 11th Floor, Los Angeles, CA 90013; 1-800-927-4357; www.insurance.ca.gov; 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.; or
c. Request an independent medical review through the California Department of Insurance. The Insured Person is not required to request an external review from Us.

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

External Review Procedure

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

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

   An external review may be requested within 6 months after the Insured Person receives Our adverse benefit determination or longer if the circumstances of the case warrant the extension. 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. The Insured Person has the option to request an external review through Us or an External Independent Medical Review through the California Department of Insurance.
2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person.
3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.
4. We will review the request and if it is:
   a. Complete we will initiate the external review and notify the Insured Person of:
      i. The name and contact information for the assigned independent review organization or the appropriate regulatory contact person 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 appropriate regulatory contact person 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 six (6) months 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.

Right to External Independent Medical Review

An Insured Person may apply to the Department of Insurance for an External Independent Medical Review if their grievance remains unresolved after 30 days, or 3 days in case of a grievance that requires an expedited review. The Insured's request for an External Independent Medical Review must be submitted to the Department within six months after the Insured Person receives the Final Adverse Benefit Determination notice. However, the Commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

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

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

California Department of Insurance

Health Claims Bureau, IMR Unit
300 S. Spring Street
11th Floor
Los Angeles, CA 90013
Inside State Toll-Free: 1-800-927-4357
Outside State: 1-213-897-8921
Fax: 1-213-897-9641
TDD: 1-800-482-4833

Questions Regarding Appeal Rights

Contact Customer Service at 1-877-246-6997 with questions regarding the Insured's rights to an Internal Appeal and External Independent Medical Review.

Underwritten by:

National Guardian Life Insurance Company

as policy form # NBH-280 (2015) CA NPPO

Claims Administered by:

Summit America Insurance Services
An Ascension Company
P.O. Box 25936 • Overland Park, KS 66225
1-877-246-6997 • FAX: 1-913-327-7520
Hours of Operation: M–F 8:30–5:00 CST
www.summitamerica-ins.com
claims@summitamerica-ins.com

Serviced by:

Ascension
P.O. Box 25936 • Overland Park, KS 66225
1-800-955-1991
Hours of Operation: M–F 8:30–5:00 CST

For a copy of the Company's Privacy Notice, you may go to:
www.commercialtravelers.com/privacy.html
or ***Request one from the Health office at your school***
or ***Request one from the Plan Administrator:***
Commercial Travelers Insurance Company
c/o Privacy Officer • 70 Genesee St. • Utica, NY 13502

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

Representations of this Plan must be approved by the Company.

Network Provider:

First Health Network
1-800-226-5116 • www.myfirsthealth.com

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 UNIVERSITY

National Guardian Life Insurance Company

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

Administrative Office: Personal Insurance Administrators, Inc.
P.O. Box 6040, Agoura Hills, CA 91376-6040

ADMINISTRATIVE CHANGE ENDORSEMENT

ENDORSEMENT SCHEDULE		
Policy Owner	Attached to Policy No.	Effective Date of Coverage
University of Redlands	2017E4A14	August 17, 2017

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

The policy is amended to delete the following definition in its entirety:

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

and replace with the following:

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

In every other way, the Policy remains as is.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

Mark T. Solverud

President

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

_____
Countersignature of Licensed
Resident Agent, where required

PLEASE ATTACH THIS ENDORSEMENT TO YOUR POLICY.

NACE-1/15

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

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

AMENDMENT RIDER

The Policy form NBH-280 (2015) CA NPPO and Certificate form NBHCert-280 (2015) CA NPPO to which this Rider is attached are amended as described below. This Amendment is effective on the Policy Effective Date as stated on the application.

SECTION IV DESCRIPTION OF BENEFITS
The term "Expanded Alpha Feto Protein Program" is deleted and replaced with "California Prenatal Screening Program."

The Home Health Care Services paragraph is deleted in its entirety and replaced with the following:

Home Health Care Services for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary. Home Health Care visits related to maternity care will be payable under the Maternity Benefit and not this Benefit**.**

Rehabilitation Services: Up to 2 hours per visit (nurse, medical social worker, physical/occupational/speech therapist) or three (3) hours for home health aide, up to 3 visits per day and unlimited visits per Policy Year are covered.

Habilitation Services: Up to 2 hours per visit (nurse, medical social worker, physical/occupational/speech therapist) or three (3) hours for home health aide, up to 3 visits per day and unlimited visits per Policy Year are covered.

In every other way, the Policy remains as is.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

Mark J Solveson

President

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

_____
Countersignature of Licensed
Resident Agent, where required

Value Added Service

The following service is not part of the Plan underwritten by National Guardian Life Insurance Company. This value added option is provided by Summit America Insurance Services, an Ascension Company, in partnership with Scholastic Emergency Services.

Global Emergency Services

The following description of the Scholastic Emergency Services Program has been included in this brochure for the convenience of the student and in no way affects the coverage provided by the Student Health Insurance Plan described herein. Scholastic Emergency Services is not insurance. It does not pay for transportation or medical costs. Global emergency services are provided by Scholastic Emergency Services (SES), an Assist America partner.

Scholastic Emergency Services (SES) is the nation's foremost provider of global emergency services designed specifically for the active student lifestyle. For any medical difficulty encountered 100 miles (150 km) away from home or campus, SES is the lifeline students can depend on with just a simple phone call. SES handles travel emergencies of every kind and even provides some services to students while on campus.

One simple phone call to the number on your SES identification card will connect you to:

- A state-of-the-art Operations Center
- Worldwide response capabilities
- Experienced crisis management professionals
- Air and ground ambulance service providers

SES completely arranges and pays for the assistance services it provides without limits on the cost. This alleviates many of the obstacles and potential expenses that can be caused by medical emergencies away from home or campus. SES is not insurance; rather it is a provider of global emergency services. SES services do not replace medical insurance during emergencies. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage.

Key Services

- Medical consultation, evaluation and referral
- Hospital admission assistance
- Emergency medical evacuation
- Medical monitoring
- Emergency medical evacuation and repatriation of remains
- Prescription assistance
- Compassionate visit
- Care of minor children
- Emergency trauma counseling
- Lost luggage assistance
- Interpreter and legal referrals
- Pre-trip information
- Return of vehicle
- And much more...

All services must be arranged and provided by SES. No claims for reimbursement will be accepted. The SES services in this brochure are only intended to serve as a general overview of the emergency travel assistance services available. The services available to you through your plan may vary from what is listed in this brochure. For a complete description of the services that are provided to you by your plan, please consult your service certificate provided by your school's program administrator and/or the fulfillment material provided by SES.

How to Access Services

If you require medical assistance and are more than 100 miles from your permanent residence or campus or are in another country, call the SES Operations Center at **(877) 488-9833** (inside USA), **+1 (609) 452-8570** (outside USA), or email **medservices@assistamerica.com**. Please download an ID card from **www.4studenthealth.com/redlands** and carry it with you at all times.

Please provide the following information when you call:

- Your name, telephone number, and relationship to the patient
- Patient's name, age, gender, reference number, and school
- Name, location, and telephone number of hospital or treating doctor if applicable
- Reference Number ***01-SES-SUM-08123***

Conditions

SES will not provide services in the following instances:

- Travel undertaken specifically for securing medical treatment
- Injuries resulting from participation in acts of war or insurrection
- Commission of unlawful act(s)
- Attempt at suicide
- Incidents involving the use of drugs unless prescribed by a physician
- Transfer of member from one medical facility to another medical facility of similar capabilities and providing a similar level of care

SES will not evacuate or repatriate a member:

- Without medical authorization
- With mild lesions, simple injuries such as sprains, simple fractures, or mild sickness which can be treated by local doctors and do not prevent the member from continuing his/her trip or returning home
- With a pregnancy over six months
- With mental or nervous disorders unless hospitalized

Exclusions

- Trips exceeding 120 days from legal residence or campus without prior notification to SES (separate purchase of Expatriate coverage is available)

While assistance services are available worldwide, transportation response time is directly related to the location/jurisdiction where an event occurs. SES is not responsible for failing to provide services or for delays in the delivery of services caused by strikes or conditions beyond its control, including by way of example and not by limitation, weather conditions, availability of airports, flight conditions, availability of hyperbaric chambers, communications systems, or where rendering of service is limited or prohibited by local law or edict.

All consulting physicians and attorneys are independent contractors and not under the control of SES. SES is not responsible or liable for any malpractice committed by professionals rendering services to a member.