COMMERCIAL CASUALTY INSURANCE COMPANY

5814 Reed Road, Fort Wayne, Indiana 46835

STUDENT BLANKET HEALTH INSURANCE

POLICYHOLDER:	Wayne State University (Policyholder, You, or Your)
POLICY NUMBER:	CCIC1819MISHIP59
POLICY EFFECTIVE DATE:	August 1, 2018
POLICY TERMINATION DATE:	July 31, 2019
STATE OF ISSUE:	Michigan

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Policy between Commercial Casualty Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Policyholder. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred due to a Covered Sickness or a Covered Injury which results in Covered Medical Expenses.

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

This Certificate takes effect on the effective date at 12:00 a.m. local time at the Policyholder's address. We must receive the Policyholder's signed application and the initial Premium for it to take place.

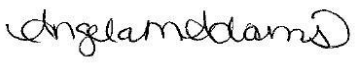
Term of the Certificate
The Certificate terminates at 11:59 p.m. local time at the Policyholder's address.
The following pages form a part of this Certificate as fully as if the signatures below were on each page.

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

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE CERTIFICATE. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

Non-Participating
Non-Renewable

President
Andrew M. DiGiorgio



Secretary
Angela Adams

Underwritten by: Commercial Casualty Insurance Company
5814 Reed Road Fort Wayne, IN 46835

Administrator: Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104
877-657-5030

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SCHEDULE OF BENEFITS

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

Non-Preferred Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Preferred Provider. Benefits are paid at 60% of the Usual and Reasonable charge.

Deductible:	Preferred Provider	Individual: $150
	Non-Preferred Provider	Individual: $150
Out-of-Pocket Maximum:	Preferred Provider:	Individual: $5,000 Family: $10,000
	Non-Preferred Provider:	Individual: $5,000 Family: $10,000

Coinsurance Amount:

Preferred Provider: 80% of the Preferred Allowance (PA) for Covered Medical Expenses unless otherwise stated below.

Non-Preferred Provider: 60% of the Usual and Reasonable (U&R) charge for Covered Medical Expenses unless otherwise stated below.

Benefit Payment for Preferred Providers and Non-Preferred Providers

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

Preferred Provider Organization:

To locate a Preferred Provider in Your area, consult Your Provider Directory or call toll free (877) 657-5030 or visit Our website at www.cofinity.net.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED CERTIFICATE WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A PREFERRED OR NON-PREFERRED PROVIDER.**
4. **UNLESS OTHERWISE SPECIFIED BELOW THE MEDICAL PLAN DEDUCTIBLE WILL ALWAYS APPLY.**

BENEFITS FOR COVERED INJURY/SICKNESS	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Hospital Room & Board Expenses and miscellaneous services and supplies. Subject to Semi-Private room rate unless intensive care unit is required. Pre-Certification required	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Preadmission Testing	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

Physician's Visits while Confined: Limited to one (1) per day of Confinement when not related to surgery	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Surgery: Pre-Certification required		
Surgeon Services	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Registered Nurse Services for private duty nursing while Confined Pre-Certification required	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Physical Therapy (inpatient) Pre-Certification required	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Skilled Nursing Facility Expense Benefit Pre-Certification required	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Benefit	Same as any other Covered Sickness	
Substance Use Disorder Benefit	Same as any other Covered Sickness	
Outpatient Benefits		
Outpatient Surgery:		
Surgeon Services	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, Physical Therapy, occupational therapy, Chiropractic Care and speech therapy	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Cardiac rehabilitation and pulmonary rehabilitation Subject to Unlimited visits per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Physical Therapy, Occupational therapy and Chiropractic Care subject to combined limit of Unlimited visits per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Speech Therapy Unlimited visits per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Habilitative Services		
Physical Therapy and Occupational therapy Unlimited visits per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Speech Therapy Unlimited visits per Policy Year	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Emergency Services Expenses	80% of Preferred Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses
In Office Physician's Visits includes care by Primary Physician, specialist, consultant, and any other licensed practitioner operating within the scope of his or her license	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Urgent Care Centers or Facilities	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

Outpatient Facility Fee	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Diagnostic Imaging Services	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
CT Scan, MRI and/or PET Scans	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Shots and Injections unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Prescription Drugs Retail Pharmacy No cost sharing applies to ACA Preventive Care medications filled at a participating network pharmacy.		
TIER 1 Generic	100% of Preferred Allowance for Covered Medical Expenses after copayment Copayment: $25 Deductible Waived	Not Covered
TIER 2 Preferred Drug	100% of Preferred Allowance for Covered Medical Expenses after copayment Copayment: $50 Deductible Waived	Not Covered
TIER 3 Non-Preferred Drug	100% of Preferred Allowance for Covered Medical Expenses after copayment Copayment: $50 Deductible Waived	Not Covered
Specialty Prescription Drugs		
TIER 4 Specialty Prescription Drugs	100% of Preferred Allowance for Covered Medical Expenses after copayment Copayment: $50 Deductible Waived	Not Covered
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Home Health Care Expenses	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospice Care Coverage	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Benefit	Same as any other Covered Sickness	

Substance Use Disorder Benefit	Same as any other Covered Sickness	
Allergy Testing	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Allergy Injections/Treatment	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Ambulance Service ground and/or air, water transportation	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Braces and Appliances	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Durable Medical Equipment	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Dialysis Treatment	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Maternity Care	Same as any other Covered Sickness	
Routine Newborn Care	Same as any other Covered Sickness	
Nutritional Counseling	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Consultant/Specialist Physician Services when requested by the attending Physician	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Covered Clinical Trials	Same as any other Covered Sickness	
Accidental Injury Dental Treatment for Insured Person's over age 18	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Non-emergency Care While Traveling Outside of the United States	60% of Usual and Reasonable Charge for Covered Medical Expenses Subject to $1,000 maximum per Policy Year	
Medical Evacuation Expense	100% Usual and Reasonable Charge for Covered Medical Expenses Subject to $50,000 maximum per Policy Year	
Repatriation Expense	100% Usual and Reasonable Charge for Covered Medical Expenses Subject to $25,000 maximum per Policy Year	

Pediatric Dental Care Benefit (to the end of the month in which the Insured Person turns age 19) Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Emergency Dental Routine Dental Care Endodontic Services Prosthodontic Services Medically Necessary Orthodontic Care	See Benefit for limitations 100% of Preferred Allowance for Preventive Dental Care 80% Usual and Reasonable 80% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable	See Benefit for limitations 100% of the Usual and Reasonable Charge for Preventive Services 80% Usual and Reasonable 80% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable
Adult Dental Care Benefit (age 19 and older) Preventive Dental Care Limited to 2 dental exams every 12 months The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care: Emergency Dental Routine Dental Care Maximum benefit $725 per Policy Year, subject to a $25 Deductible per Policy Year	See Benefit for limitations 80% of Preferred Allowance for Preventive Dental Care 50% Usual and Reasonable 50% Usual and Reasonable	See Benefit for limitations 80% of the Usual and Reasonable Charge for Preventive Services 50% Usual and Reasonable 50% Usual and Reasonable
Pediatric Vision Care Benefit (to the end of the month in which the Insured Person turns age 19) Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames or contact lenses in lieu of frames and lenses, or if Medically Necessary, per Policy Year	100% of Usual and Reasonable Charge for Covered Medical Expenses	100% of Usual and Reasonable Charge for Covered Medical Expenses
Adult Vision Care (age 19 and older) Routine Eye Exam once every 12 months	100% of Preferred Allowance for Covered Medical Expenses Copayment: $25	100% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25

Organ Transplant Travel and lodging expenses a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility.	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Telemedicine Service	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Chemotherapy and Radiation Therapy	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Infusion Therapy	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Prosthetic Devices	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Weight Loss Services Benefit, includes one (1) Bariatric Surgery per lifetime	80% of Preferred Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mandated Benefits		
Autism Spectrum Disorder	Same as any other Covered Sickness, subject to the limitations described in the Benefit	
Breast Reconstructive Surgery	Same as any other Covered Sickness, subject to the limitations described in the Benefit	
Diabetes Treatment and Self-Management Training Benefit	Same as any other Covered Sickness, subject to the limitations described in the Benefit	
Must Offer Benefits		
Breast Cancer Diagnostic Services, Breast Cancer Outpatient Treatment Services, and Breast Cancer Rehabilitative Services; and Coverage for Breast Cancer Screening Mammography	Same as any other Covered Sickness, subject to the limitations described in the Benefit	

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum for Double Dismemberment or Loss of Life $10,000

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 Certificate.

SECTION I - ELIGIBILITY

You are eligible for Coverage under this Certificate. Coverage includes Dependent coverage.

Students must attend classes for the first 31 days beginning with the first day for which coverage is effective. Any student withdrawing from the College during the first 31 days after the Effective Date of coverage shall not be covered under the insurance plan. A full refund of premium will be made, minus the cost of any claim benefits paid by the Policy. Students who graduate or withdraw from the College after 31 days, whether involuntarily or voluntarily, will remain covered under the Policy for the term purchased and no refund will be allowed.

Students withdrawing due to a medical withdrawal due to a Sickness or Injury, must submit documentation or certification of the medical withdrawal to Us at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the date of the medical leave from school. Students will remain covered under the Policy for the term purchased and no refund will be allowed.

All International Students are required to have a J-1 F-1 or M1 and dependents have a J-2 F-2 or M-2 Visa to be eligible for this insurance plan.

We maintain the right to investigate eligibility status and attendance records to verify that the Policy eligibility requirements have been met. If We discover that the Policy eligibility requirements have not been met, Our only obligation is refund of premium less any claims paid.

Eligibility requirements must be met each time premium is paid to renew Coverage.

Who is Eligible
All registered International students taking credits are required to have health insurance coverage. Students are automatically enrolled in the Student Health Insurance Plan at registration and the premium is added to the student's tuition fees and do not have the option to waive coverage.

Who is not Eligible
The following students are not eligible to enroll in the insurance plan:

- students enrolled exclusively in online courses or whose enrollment consists entirely of short-term courses;
- students taking distance learning, home study, correspondence, television courses, or courses taken for audit do not fulfill the eligibility requirements that the student actively attend classes. The online restriction does not apply to students who are completing their degree requirements while engaged in practical training.

SECTION II - EFFECTIVE AND TERMINATION DATES

Effective Dates: Insurance under this Certificate will become effective on the later of:

1. The Policy Effective Date;
2. The beginning date of the term for which premium has been paid;
3. The day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed;
5. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be not more than 48 hours later than the departure from the Home Country.

Dependent's coverage, under the Voluntary Participation Basis, becomes effective on the later of:

1. The day after the date of postmark when the Enrollment Form is mailed; or
2. The beginning date of the term for which premium has been paid; or
3. The day after the date the required individual Enrollment Form and premium payment are received by Us or Our authorized agent. This applies only when premium payment is made within 31 days of Your enrollment in the School's insurance plan; or

4. The Policy Effective Date.

The Enrollment Period will run from the start of the quarter or semester for which coverage is desired.

Special Enrollment -Qualifying Life Event
You, and Your Spouse or Child can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other health plan due to:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated for You or Your Dependent's Coverage; or
7. A Child no longer qualifies for coverage as a Child under the other health plan.

You, Your Spouse or Child can also enroll 60 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

In addition, You, and Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following event:

1. You or Your Spouse or Child loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Child become eligible for Medicaid or a state child health plan.

We must receive notice and Premium payment within 31,60 days of the loss of coverage. The effective date of Your coverage will depend on when We receive proof of Your loss of coverage under another health plan and appropriate premium payment. Your coverage shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which you lose your coverage providing premium for Your coverage has been paid; (3) the date the Policyholder's term of coverage begins; or (4) the date You become a member of an eligible class of persons.

Termination Dates: Your insurance will terminate on the earliest of:

1. The date this Certificate terminates for all Insured Persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date You cease to be eligible for the insurance; or
4. The date You enter military service; or
5. For International Students, the date they cease to meet Visa requirements; or
6. For International Students, the date they depart the Country of Assignment for his/her Home Country (except for scheduled school breaks); or
7. On any premium due date the Policyholder fails to pay the required premium for You except as the result of an inadvertent error and subject to any Grace Period provision.

Dependent Child Coverage:

Newly Born Children - A newly born child of Yours will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. If additional premium is required, to continue coverage beyond this initial 31-day period, You must notify Us of the birth so We can generate an updated premium bill so a timely premium payment is made. If an additional premium is not required, We request that the Insured Student notify Us of the birth to ensure proper claims adjudication.

Adopted Children - Dependent Child Coverage also applies to any child adopted or placed for adoption irrespective of whether the adoption has become final.

We must receive:
1. Notification of a child's placement for adoption within 31 days of the placement; and
2. Any premium required for the child.

We will provide coverage for the child placed for adoption as long as You
1. Have custody of the child;
2. Your coverage under this Certificate remains in effect; and
3. The required premiums are furnished to Us.

As it pertains to this provision:
Child means, in connection with an adoption or place for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child's placement with a person terminates upon the termination of the legal obligation.

Handicapped Children: If:
1. There is Dependent coverage; and
2. The Certificate provides that coverage of a Dependent child will terminate upon attainment of a specified age.

We will not terminate the coverage of such child due to attainment of that age while the child is and continues to be both:
1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
2. Chiefly dependent upon You for support and maintenance.

Proof of such incapacity and dependence shall be furnished to us within thirty-one days of the child's attainment of the limiting age. Upon request, We may require proof satisfactory to it of the continuance of such incapacity and dependency. We may not request this more frequently than annually after the two-year period following the child's attainment of the limiting age.

Extension of Benefits: Coverage under this Certificate ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for You will be extended as follows:
1. If You are 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.

Dependents that are newly acquired during Your Extension of Benefits period are not eligible for benefits under this provision.

Reinstatement Of Reservist After Release From Active Duty: If Your insurance or an eligible Dependent's insurance ends due to Your being called or ordered to active duty, such insurance will be reinstated without any waiting period when You return to School and satisfy the eligibility requirements defined by the School or College.

Refund of Premium: Premiums received by Us are fully earned upon receipt. Refund of Premium will be considered only:
1. For any student who does not attend school during the first 31 days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the Premium will be made minus any claims paid.
2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of Premium (less any claims paid) will be made for such person upon written request received by Us within 90 days of withdrawal from school.
3. For International Students, Scholars, and/or their covered Dependents. We will refund a pro rata portion of the premium actually paid (less any claims paid) for any individual who:
    - Withdraws from School during their first semester; and
    - Returns to their Home Country on a permanent basis.

A written request must be sent to use within 60 days of such departure.
No other refunds will be allowed.

SECTION III – DEFINITIONS

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

Accident means a sudden, unforeseeable external event which directly and from no other cause, results in an Injury to the Insured Person.

Ambulance Service means transportation to and from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, in a Medical Emergency.

Ambulatory Surgical Center means a facility which meets licensing and other legal requirements and which:
1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed Registered Nurse at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has x-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

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.

Assistant Surgeon means a Physician who assists the Surgeon who actually performs a surgical procedure.

Brand-Name Prescription Drug means a Prescription Drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right. Refer to the Formulary for the tier status.
Certificate: The Certificate issued by Us, including the Schedule of Benefits and any attached riders.

Coinsurance means the percentage of Covered Medical Expenses that We pay. The Coinsurance percentage is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

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.

Confinement/Confined means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a seventy-two (72) hour period, will be considered a continuation of the Confinement. Confinement does not include observation, which is a review or assessment of eighteen (18) hours or less, of an Insured Person's condition that does not result in admission to a Hospital or health care facility.

Copayment means a specified dollar amount You must pay for specified Covered Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

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

Covered Injury/Injury means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause. All injuries sustained in any one (1) Accident, all related conditions and recurrent symptoms of these injuries are considered a single Injury.

Covered Medical Expense means those Medically Necessary 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;
3. Not in excess of the Preferred Allowance; and
4. Incurred while Your Certificate is in force, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means an illness, disease or condition including pregnancy and Complications of Pregnancy that impairs Your normal function of mind or body and which is not the direct result of an Injury which results in Covered Medical Expenses. Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Custodial Care means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

Deductible means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Certificate. The amount of the Deductible, if any, will be shown in the Schedule of Benefits.

Dependent means:
1. An Insured Student's lawful spouse or lawful Domestic Partner;
2. An Insured Student's dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student's unmarried biological or adopted child or stepchild who has reached age 26 and who is:
   a. primarily dependent upon the Insured Student for support and maintenance; and
   b. incapable of self-sustaining employment by reason of intellectual disability, mental illness or disorder or physical handicap.
   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Durable Medical Equipment means a device which:
1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by You;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating Your Sickness or Injury; and
5. Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.

Durable Medical Equipment does not include:
1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than You;
3. Health exercise equipment; and
4. Equipment that may increase the value of Your residence.

Effective Date means the date coverage becomes effective.

Elective Surgery or Elective Treatment means those health care services or supplies not medically necessary for the care and Treatment of a Covered Injury or Covered Sickness. Elective surgery does not include Plastic, Cosmetic, or Reconstructive Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Eligible Student means a student who meets all eligibility requirements of the School named as the Policyholder or Dependent of the Insured Student.

Emergency Medical Condition means a Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. 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;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

Essential Health Benefits mean benefits that are defined in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of Covered Services:

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.

Experimental/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see definition of Medically Necessary/Medical Necessity provision

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 indicates the type of drug and tier status.

Gender Dysphoria means a conflict between Your physical gender and the gender with which You identify. The identity conflict must continue over at least 6 months and You must meet the definition of Gender Dysphoria as described by the American Psychiatric Association.

Generic Prescription Drug means any Prescription Drug that is not a Brand-Name Prescription Drug. Refer to the Formulary for the tier status.

Habilitation/Habilitative Services means health care services that help You keep, learn, or improve skills and functions for daily living. Habilitative Services may include such services as Physical Therapy, occupational therapy, and speech therapy.

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

of Yours while insured under this Certificate.

Home Health Care Agency means an agency that:

1. is constituted, licensed and operated under the provision of Title XVIII of the Federal Social Security Act, or qualified to be so operated if application was made, and certified by the jurisdiction in which the Home Health Care plan is established; and
2. is engaged primarily in providing skilled nursing facility services and other therapeutic services in the Insured Person's Home under the supervision of a Physician or a Nurse; and
3. maintains clinical records on all patients.

Home Health Care means the continued care and treatment of an Insured Person if:

1. institutionalization of the Insured Person would have been required if Home Health Care was not provided; and
2. the Insured Person's physician establishes and approves in writing the plan of treatment covering the Home Health Care service; and
3. Home Health Care is provided by:
   a. a Hospital that has a valid operating certificate and is certified to provide Home Health Care services; or
   b. a public or private health service or agency that is licensed as a Home Health Agency under title 19, subtitle 4 of the General Health Article to provide coordinated Home Health Care.

Hospice: means a coordinated plan of home and Inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual, social, and economic stresses.

Hospital: A facility which provides diagnosis, Treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax- supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include Rehabilitative facilities if such is specifically required for Treatment of physical disability.
Facilities primarily treating drug addiction or Alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

Immediate Family Member means You and Your spouse or the parent, child, brother or sister of You or Your spouse.

Insured Person means an Insured Student or Dependent of an Insured Student while insured under this Certificate.

Insured Student means a student of the Policyholder who is eligible and insured for coverage under this Certificate.

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 as a student or in educational research activities through the Policyholder.

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

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

Medically Necessary or **Medical Necessity** means health care services that a Physician, exercising prudent clinical

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

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply 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.

Non-Preferred Providers are Physicians, Hospitals and other healthcare providers who have not agreed to any pre-arranged fee schedules.

Non-Preferred Drug means a drug that makes up the formulary drug list and may have a higher out-of-pocket cost.

Nurse means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:
1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse's license or certificate who does not ordinarily reside in Your home or is not related to You by blood or marriage.

Organ Transplant means the moving of an organ from one body to another or from a donor site to another location of the person's own body, to replace the recipient's damaged, absent or malfunctioning organ.

Out-of-Pocket Maximum: means the most You will pay during a Policy Year before Your Coverage begins to pay 100% of the allowed amount. This limit will never include Premium, balance-billed charges or health care this Certificate does not cover. Your Non-Preferred Provider payments or other non-covered expenses do not count toward this limit.

Physical Therapy means any form of the following:
1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

Physician means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this Certificate, and who is not:
1. The Insured Person;
2. An Immediate Family Member; or
3. A person employed or retained by the Insured Person.

Preadmission Testing means tests done in conjunction with and within 5 days of a scheduled surgery where an operating room has been reserved before the tests are done.

Preferred Allowance means the amount a Preferred Provider will accept as payment in full or Covered Medical Expenses.

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

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

Qualifying Life Event means an event that qualifies a Student to apply for coverage for him/herself or for the Insured Student's Dependent due to a Qualifying Life Event under this Certificate.

Rehabilitative means the process of restoring Your ability to live and work after a disabling condition by:
1. Helping You achieve the maximum possible physical and psychological fitness;
2. Helping You regain the ability to care for yourself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

Reservist means a member of a reserve component of the Armed Forces of the United States. Reservists also includes a member of the State National Guard and the State Air National Guard.

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

Skilled Nursing Facility – a facility, licensed, and operated as set forth in applicable state law, which:
1. mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial facility or similar place.

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

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

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

Surgeon means a Physician who actually performs surgical procedures.

Telemedicine means the use of an electronic media to link Insured Persons with Physicians in different locations. To be considered Telemedicine, the Physician must be able to examine the Insured Person via a real-time, interactive audio or video, or both, telecommunications system and the Insured Person must be able to interact with the off-site health care professional at the time the services are provided.

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.

Urgent Care means short-term medical care performed in an Urgent Care Facility for non-life-threatening conditions that can be mitigated or require care within forty-eight (48) hours of onset.

Urgent Care Facility means a Hospital or other licensed facility which provides diagnosis, Treatment, and care of persons who need acute care under the supervision of Physicians.

Usual and Reasonable means the average 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.

You, or Your(s) means an Insured Person, Insured Student, or Dependent of an Insured Student while insured under this Certificate.

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

We, Us, or **Our** means Insurance Company or its authorized agent. Also referred to as the Company.

SECTION IV - DESCRIPTION OF BENEFITS

Benefit Payments for Preferred Providers and Non-Preferred Providers
This Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. This Certificate provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

Preferred Provider Organization
If You use a Preferred Provider, this Certificate will pay the Coinsurance percentage of the Preferred Allowance shown in the Schedule of Benefits for Covered Medical Expenses

If a Non-Preferred Provider is used, this Certificate 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 Your responsibility.

Note, however, that We will pay at the Preferred Allowance level for Treatment by a Non-Preferred Provider if:
1. there is no Preferred Provider in the service area available to treat You for a specific Covered Injury or Covered Sickness; or
2. there is an Emergency Medical Condition and You cannot reasonably reach a Preferred Provider. This benefit will continue to be paid for the Emergency Services until You can reasonably be expected to safely transfer to a Preferred 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-Preferred Provider.

You should be aware that Preferred Provider Hospitals may be staffed with Non-Preferred Providers. Receiving services from a Preferred Provider does not guarantee that all charges will be paid at the Preferred Provider level of benefits. It is important that You verify that Your Physicians are Preferred Providers each time You call for an appointment or at the time of service.

If You are undergoing an active course of Treatment with a Preferred Provider, You may request continuation of Treatment by such Preferred Provider in the event the Preferred Provider's contract has terminated with the Preferred Provider organization. We shall notify You of the termination of the Preferred Provider's contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining and alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in Your ongoing Treatment. We shall permit You to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of at least 60 days from the date of the notice to You of the termination except that if You are in the second trimester of pregnancy at the time of the termination and the provider is treating You during the pregnancy. The transitional period must extend through the provision of postpartum care directly related to the pregnancy.

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 Your Dependents 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 You or Your Dependents 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.

For additional information visit the United States Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations.

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 Certificate benefits will be amended to comply with such changes.

The following are shown in the Schedule of Benefits:

- Deductible
- Any specified benefit maximums
- Coinsurance percentages
- Copayment amounts
- Out-of-Pocket Maximums;
- Use of Preferred Provider, if any.

Out-of-Pocket Maximum
The Out-of-Pocket Maximum is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses You have to pay. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Maximum. However, Your Coinsurance amounts, Deductibles and Copayments will apply toward the Out-of-Pocket Maximum.

Treatment of Covered Injury and Covered Sickness Benefit
If:
1. You incur 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 or the Preferred Allowance 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 Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness.

Pre-Certification Process
You are responsible for calling Us at the phone number found on the back of Your ID card and starting the Pre-Certification process. For Inpatient services or surgery, the call should be made at least 5 working days prior to Hospital Confinement

or surgery. In the case of an emergency, the call should take place as soon as reasonably possible.

The following Inpatient services or supplies require Pre-Certification:
1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of substance abuse, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. Surgery;

Pre-Certification is not required for a medical emergency or Urgent Care or Hospital Confinement for maternity care.

Additionally, no authorization requirement will apply to obstetrical or gynecological care provided by in-network providers.

Pre-Certification is not a guarantee that Benefits will be paid.

Your Physician will be notified of Our decision as follows:
1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone;
3. For any other covered services requiring Pre-Certification, We will contact the Provider in writing or by telephone regarding Our decision.

Our agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Determination made by Our agent will be in writing and will include:
1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.
3. Notice of the availability, upon Your request or Your designee, of the clinical review criteria relied upon to make the Adverse Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

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

If You have any questions about Your Pre-Certification status, You should contact Your Provider.

Inpatient Benefits

1. **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.

2. **Intensive Care Unit,** including 24-hour nursing care.

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

4. **Preadmission Testing** for routine tests performed as a preliminary to Your being admitted to a Hospital. These tests must be performed within 5 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 Certificate, 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.

5. **Physician's Visits while Confined** not to exceed one (1) 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.

6. **Inpatient Surgery including Surgeon, Anesthetist, and Assistant Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. This benefit is not payable in addition to Physician's visits.

   Through the Same Incision. 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.

   Through Different Incisions. If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
   - For the procedure with the highest Allowed Amount; and
   - 50% of the amount We would otherwise pay for the other procedures.

7. **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.

8. **Physical Therapy while Confined** when prescribed by the attending Physician.

9. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for Custodial Care or residential care is not covered.

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

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

Outpatient Benefits

1. **Outpatient Surgery including Surgeon, Anesthetist, and Assistant 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. This benefit is not payable in addition to Physician's visits.

   Through the Same Incision. 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.

   Through Different Incisions. If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
   - For the procedure with the highest Allowed Amount; and
   - 50% of the amount We would otherwise pay for the other procedures.

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

supplies, including:
a. Operating room;
b. Therapeutic services;
c. Oxygen, oxygen tent; and
d. Blood and blood plasma.

3. **Rehabilitative Therapy** when prescribed by the attending Physician, limited to one visit per day.

4. **Habilitative Therapy** when prescribed by the attending Physician, limited to one visit per day.

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

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

7. **Urgent Care Centers or Facilities** for services provided at an Urgent Care Center or Facility, as shown in the Schedule of Benefits.

8. **Outpatient Facility Fee** when You are treated for a Covered Sickness or Covered Injury in an appropriately licensed outpatient facility including an ambulatory surgical center. Operating room fees for surgery are paid under the Outpatient Surgery Miscellaneous Benefit and not this benefit.

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

10. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.

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

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

13. **Prescription Drugs** are medications filled in an outpatient pharmacy 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. Some outpatient prescription drugs are subject to pre-certification. These prescription requirements help your prescriber and pharmacists check that your outpatient prescription drug is clinically appropriate using evidence-based criteria.

    a. **Off-Label Drug Treatments** - When prescription drugs are provided as a benefit of the issued Certificate, 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, including cancer, HIV or 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 States 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. **Dispense as Written (DAW)** – If a prescriber prescribes a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available and specifies: "Dispense as Written" (DAW), You will pay the cost sharing for the Brand-Name Prescription Drug. If a prescriber does not specify DAW and the Member requests a covered Brand-Name Prescription Drug where a Generic Prescription Drug equivalent is available, the Member will be responsible for the cost difference between the Brand-Name Prescription Drug and the Generic Prescription Drug equivalent, and the cost sharing that applies to Brand-Name Prescription Drugs.

c. **Investigational Drugs and Medical Devices** – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

d. **Specialty Prescription Drugs** may have limited access or distribution and are limited to no more than a 30-day supply.

Specialty Drugs – are Prescription Drugs which:

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

e. **Step Therapy** – When medications for the Treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us upon completion of the review if all necessary information to perform the override review has been provided, under the following documented circumstances:

1) The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of Your disease or medical condition; or
2) Based on sound clinical evidence or medical and scientific evidence:
   a) The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured and known characteristics of the drug regimen; or
   b) The prescribing practitioner can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to You.

f. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist check that the Outpatient Prescription Drug is used correctly and safely We rely on medical guidelines, FDA-approved recommendations and other criteria developed by Us to set these quantity limits.

g. **Tier Status**--The tier status of a Prescription Drug may change periodically. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at www.chpstudenthealth.com or by calling the number on Your ID card.

h. **Compounded Prescription Drugs** will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, do not contain bulk chemicals, and are obtained from a pharmacy that is approved for compounding. Compounded Prescription Drugs may require Your Provider to obtain Preauthorization. Compounded Prescription Drugs will be covered as the tier associated with the highest tier ingredient.

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

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

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

j. **Supply Limits** – We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost Sharing amount for up to a 30-day supply.

k. **Tobacco cessation prescription and over-the-counter drugs**: Tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drug treatment regimens will be subject to the cost sharing in your schedule of benefits. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.chpstudenthealth.com or call 877-657-5030

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

15. **Home Health Care Expense** for Home Health Care for You when, otherwise, Hospitalization or Confinement in a Skilled Nursing Facility would have been necessary.

16. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, You require Hospice Care, we will pay the expenses incurred for such care. You must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. You 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.

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

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

Other Benefits

1. **Allergy Testing**. This includes tests that You need such as PRIST, RAST, and scratch tests.

2. **Allergy Injections/Treatment** includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.

3. **Ambulance Service** for transportation to and from a Hospital by a licensed Ambulance whether ground, air or water Ambulance, in a Medical Emergency. . Air and water will be covered when:
   - Professional ground Ambulance transportation is not available
   - Your condition is unstable, and requires medical supervision and rapid transport
   - You are traveling from one Hospital to another and
     - The first Hospital cannot provide the Emergency Services you need

   The two conditions above are met.

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

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

6. **Dialysis Treatment** of an acute or chronic kidney ailment, provide in an Outpatient facility of a Hospital, a free-standing renal Dialysis facility or in the home. Covered services for home Treatment will include equipment, training and medical supplies. Private Duty Nursing is not covered.

7. **Maternity Benefit** for maternity charges as follows:
   a. Routine prenatal care, including genetic testing, and postnatal care

   b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the 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.

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

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

developed by national organizations that represent pediatric obstetrical and nursing professionals.

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

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

8. **Routine Newborn Care -** when expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:
   a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   b. Inpatient Physician visits for routine examinations and evaluations;
   c. Charges made by a Physician in connection with a circumcision;
   d. Routine laboratory tests;
   e. Postpartum home visits prescribed for a newborn;
   f. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and
   g. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the Treatment of such newly born child.

9. **Nutritional Counseling** for dietary counseling and Treatment for Insured Persons with an inherited metabolic disorder, such as PKU. This includes oral amino acid based elemental formulas.

10. **Consultant/Specialist Physician Services** when requested and approved by the attending Physician.

11. **Covered Clinical Trials** includes coverage for routine costs associated with Your participation in a clinical trial. Coverage does not include the studied device, equipment or drug, data collection services and any service not associated with direct clinical care to You.

12. **Accidental Injury Dental Treatment for Insured Persons over age 18** as the result of Injury. Routine dental care and Treatment are not payable under this benefit. Damage to teeth due to chewing or biting is not deemed an accidental Injury and is not covered.

13. **Non-emergency Care While Traveling Outside of the United States**

14. **Medical Evacuation Expense** The maximum benefit for Medical Evacuation, if any, is shown in the Schedule of Benefits.

    If:
    a. You are unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness;
    b. That occurs while he or she is covered under this Certificate,

    We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

    Payment of this benefit is subject to the following conditions:
    a. You must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of five or more consecutive days immediately prior to medical evacuation;
    b. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;
    c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;
    d. No benefits are payable for Usual and Reasonable Expenses after the date Your insurance terminates. However, if on the date of termination, You are in the Hospital, this benefit continues in force until the earlier of the date the

Confinement ends or 31 days after the date of termination;

e. Evacuation to Your Home Country terminates any further insurance under the Certificate for You; and
f. Transportation must be by the most direct and economical route.

15. **Repatriation Expense-**
The maximum benefit for Repatriation, if any, is shown in the Schedule of Benefits.

If You die while covered under this Certificate, We will pay a benefit. The benefit will be the necessary Usual and Reasonable charges for preparation, including cremation, and transportation of the remains to Your place of residence Your Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

16. **Pediatric Dental Care Benefit** for the following dental care services for Insured Persons (to the end of the month in which the Insured Person turns age 19):
    a. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
        1) Prophylaxis (scaling and polishing the teeth) at four (4) month intervals;
        2) Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
        3) Sealants on unrestored permanent molar teeth; and
        4) Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

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

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

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

    e. Prosthodontic services as follows:
        1) Removable complete or partial dentures, including six (6) months follow- up care; and
        2) Additional services include insertion of identification slips, repairs, relines and rebases and Treatment of cleft palate.

        Fixed bridges are not Covered unless they are required:
        1) For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
        2) For cleft palate stabilization; or
        3) Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

    f. Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.
    Procedures include but are not limited to:

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

17. **Adult Dental Care Benefit** for the following dental care services for Insured Persons age 19 and over

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

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

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

18. **Pediatric Vision Care Benefit** for Insured Persons (to the end of the month in which the Insured Person turns age 19).

We will provide benefits for:
a) One vision examination per Policy Year; and
b) One pair of prescribed lenses and eyeglass frames (or contact lenses in lieu of frames and lenses, or if Medically Necessary) per Policy Year.

19. **Adult Vision Care** for Insured Persons age 19 and over. We will provide benefits for one routine eye examination every 12 months.

20. **Chiropractic Care Benefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician. See benefits for Rehabilitation Therapy.

21. **Organ Transplant Surgery**

Recipient Surgery for Medically Necessary, non-experimental and non-investigational solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and medical expenses of an Insured Person who is the recipient of an organ transplant. This benefit does not cover routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.

Donor's Surgery for Medically Necessary transplant services required by the Insured Person when the Insured Person serves as an organ donor only if the recipient is also an Insured Person. We will not Cover the transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person's expenses will be Covered under another health plan or program.

Travel Expenses when the facility performing the Medically Necessary transplant is located more than 200 miles from an Insured Person's residence, coverage will be provided for lodging, meals and transportation expenses (coach class only) subject to the maximum benefits shown on the Schedule of Benefits.

Non-Covered Services for transportation and lodging include, but are not limited to:

a. Child care;
b. Mileage within the medical transplant facility city;
c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;
d. Frequent Flyer miles;
e. Coupons, Vouchers, or Travel tickets;
f. Prepayments or deposits;
g. Services for a condition that is not directly related or a direct result of the transplant;
h. Telephone calls;
i. Laundry;
j. Postage;
k. Entertainment;
l. Interim visits to a medical care facility while waiting for the actual transplant procedure;
m. Travel expenses for donor companion/caregiver;
n. Return visits for the donor for a Treatment of condition found during the evaluation.

22. **Telemedicine Services** for expenses incurred for Telemedicine rendered to an Insured Person, as appropriate and in lieu of a face to face consultation. Telemedicine services shall be provided by a Physician who is licensed, registered, or otherwise authorized to engage in his or her health care profession in the state where the Insured Person is located.

23. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness, as shown in the Schedule of Benefits.

24. **Infusion Therapy** for the administration of antibiotic, nutrients, or other therapeutic agents by direct infusion.

25. **Treatment for Temporomandibular Joint (TMJ) Disorders** for coverage including medical care or services to treat dysfunction or TMJ resulting from a medical cause or Injury; Office visits for medical evaluation and Treatment; X-rays of the TMJ including contrast studies, but not dental x-rays; and Myofunctional therapy and surgery to the TMJ, such as condylectomy, meniscectomy, arthrotomy, and arthrocentesis.

26. **Prosthetic Devices** to maintain or replace the body part of an Insured Person whose Covered Sickness or Injury has required the removal of that body part. This benefit shall provide expenses for medical care and attendance for an Insured Person fitted with a prosthetic device shall be covered after the attending Physician has certified the Medical Necessity or desirability for a proposed course of Rehabilitative Treatment.

27. **Weight Loss Services Benefit** for Physician supervised weight loss programs. Pre-authorization is required. We will also cover Medically Necessary bariatric surgery only when all other reasonable non-surgical options have been tried. Coverage is limited to one bariatric surgery per lifetime unless Medically Necessary to correct or reverse complications from a previous bariatric surgery procedure. This benefit does not include: food, food supplements, gastric balloons, other weight loss surgeries, jaw wiring, liposuction, physical fitness or exercise programs.

Mandated Benefits for Michigan

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

Autism Coverage for the Diagnosis of Autism Spectrum Disorders and Treatment of Autism Spectrum Disorders. Coverage under this benefit for Treatment of Autism Spectrum Disorders is limited to an Insured Person through 18 years of age. In order for the benefits to be paid We may:

1. Require a review of the Treatment consistent with current protocols and may require a Treatment Plan. If requested by Us, the cost of Treatment review shall be borne by Us as part of the benefit payable;
2. Request the results of the Autism Diagnostic Observation Schedule that has been used in the diagnosis of an Autism Spectrum Disorder for that Insured Person;
3. Request that the Autism Diagnostic Observation Schedule be performed on that Insured Person not more frequently that once every 3 years; and
4. Request that an annual development evaluation be conducted and that We receive the results of that annual development evaluation.

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

Autism Diagnostic Observation Schedule means the protocol available through western psychological services for diagnosing and assessing Autism Spectrum Disorders or any other standardized diagnostic measure for Autism Spectrum Disorders that is approved by the Commissioner, if the Commissioner determines that the diagnostic measure is recognized by the health care industry and is an evidence-based diagnostic tool.

Autism Spectrum Disorders means any of the following pervasive developmental disorders as defined by the diagnostic and statistical manual: Autistic disorder; Asperger's disorder; Pervasive developmental disorder not otherwise specified.

Diagnosis of Autism Spectrum Disorders means assessments, evaluations, or tests including the Autism Diagnostic Observation Schedule, performed by a licensed Physician or a licensed psychologist to diagnose whether an Insured Person has one of the Autism Spectrum Disorders.

Treatment of Autism Spectrum Disorders means evidence-based Treatment that includes the following care prescribed or ordered for an Insured Person diagnosed with one of the Autism Spectrum Disorders by a Physician or a licensed psychologist who determines the care to be Medically Necessary:
1. Behavioral health Treatment which includes evidence-based counseling and Treatment programs, including Applied Behavior Analysis, that meet both of the following requirements:
   (a) Are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an Insured Person.
   (b) Are provided or supervised by a board certified behavior analyst or a licensed psychologist so long as the services preformed are commensurate with the psychologist's formal university training and supervised experience.
2. Pharmacy care including medications prescribed by a licensed Physician and related services performed by a licensed pharmacist and any health-related services considered Medically Necessary to determine the need or effectiveness of the medications.
3. Psychiatric care including evidence-based direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.
4. Psychological care including evidence-based direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.
5. Therapeutic care including evidence-based services provided by a licensed or certified speech therapist, occupational therapist, physical therapist, or social worker.

Treatment Plan means a written, comprehensive, and individualized intervention plan that incorporates specific Treatment goals and objectives and that is developed by a board certified or licensed provider who has the appropriate credentials and who is operating within his or her scope of practice, when the Treatment of an Autism Spectrum Disorder is first prescribed or ordered by a Physician including a psychologist.

Breast Reconstructive Surgery for expenses incurred for prosthetic devices to maintain or replace the body parts of an Insured Person who has undergone a mastectomy. Coverage includes medical care and attendance for an Insured Person who receives reconstructive surgery following a mastectomy or who is fitted with a prosthetic device shall be covered benefits after the Insured Person's attending Physician has certified the Medical Necessity or desirability of a proposed course of Rehabilitative Treatment. The cost and fitting of a prosthetic device following a mastectomy is included.

Diabetes Treatment and Self-Management Training Benefit for the expenses incurred for the diagnosis and Treatment of Diabetes. We will also cover the following equipment, supplies, and educational training for the treatment of Diabetes, if determined to be Medically Necessary and prescribed by an allopathic or osteopathic Physician:

1. Blood glucose monitors and blood glucose monitors for the legally blind.
2. Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.
3. Syringes.
4. Insulin pumps and medical supplies required for the use of an insulin pump.
5. Diabetes self-management training to ensure that Insured Persons with Diabetes are trained as to the proper self-management and treatment of their diabetic condition.

We will also pay for the following for the treatment of Diabetes, if determined to be Medically Necessary:

1. Insulin, if prescribed by an allopathic or osteopathic Physician.
2. Non-experimental medication for controlling blood sugar, if prescribed by an allopathic or osteopathic Physician.
3. Medications used in the treatment of foot ailments, infections, and other medical conditions of the foot, ankle, or nails associated with Diabetes, if prescribed by an allopathic, osteopathic, or podiatric Physician.

Coverage for Diabetes self-management training is subject to the following:

1. Is limited to completion of a certified Diabetes education program upon occurrence of either of the following:
   a. If considered Medically Necessary upon the diagnosis of Diabetes by an allopathic or osteopathic Physician who is managing the patient's diabetic condition and if the services are needed under a comprehensive plan of care to ensure therapy compliance or to provide necessary skills and knowledge.
   b. If an allopathic or osteopathic Physician diagnoses a significant change with long-term implications in the patient's symptoms or conditions that necessitates changes in a patient's self-management or a significant change in medical protocol or treatment modalities.
2. Shall be provided by a Diabetes outpatient training program certified to receive Medicaid or Medicare reimbursement or certified by the department of community health. Training provided under this subdivision shall be conducted in group settings whenever practicable.

As used in this benefit:
Diabetes means gestational Diabetes, insulin-dependent Diabetes, and non-insulin-dependent Diabetes.

Breast Cancer Diagnostic Services, Breast Cancer Outpatient Treatment Services, and Breast Cancer Rehabilitative Services; and Coverage for Breast Cancer Screening Mammography for expenses incurred for Breast Cancer Diagnostic Services, Breast Cancer Outpatient Treatment Services, and Breast Cancer Rehabilitative Services Medically Necessary for an Insured Person. We will also provide the following coverage for Breast Cancer Screening Mammography of an Insured Person:

1. If performed on a woman 35 years of age or older and under 40 years of age, coverage for one screening mammography examination during that 5-year period.
2. If performed on a woman 40 years of age or older, coverage for one screening mammography examination every calendar year.

As used in this benefit:
Breast Cancer Diagnostic Services means a procedure intended to aid in the diagnosis of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to mammography, surgical breast biopsy, and pathologic examination and interpretation.

Breast Cancer Rehabilitative Services means a procedure intended to improve the result of, or ameliorate the debilitating consequences of, treatment of breast cancer, delivered on an inpatient or outpatient basis, including but not limited to reconstructive plastic surgery, Physical Therapy, and psychological and social support services.

Breast Cancer Screening Mammography means a standard 2-view per breast, low-dose radiographic examination of the breasts, using equipment designed and dedicated specifically for mammography, in order to detect unsuspected breast cancer.

Breast Cancer Outpatient Treatment Services means a procedure intended to treat cancer of the human breast, delivered on an outpatient basis, including but not limited to surgery, radiation therapy, chemotherapy, hormonal therapy, and related medical follow-up services.

SECTION V - ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered Accident, You sustain 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 VI - EXCLUSIONS AND LIMITATIONS

Exclusion Disclaimer: Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state imposed requirements will be administered to comply with the requirements of the federal or state guideline, whichever is more favorable to You.

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

1. **International Students Only -** Eligible expenses within Your Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which You could be eligible.
2. Treatment, service or supply which is not Medically Necessary for the diagnosis, care or treatment of the Sickness or Injury involved. This applies even if they are prescribed, recommended or approved by the person's attending physician or dentist.
3. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits
4. professional services rendered by an Immediate Family Member or anyone who lives with You.
5. weak, strained or flat feet, corns, calluses ingrown toenails except for Treatment because of Injury, infection or disease.
6. surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
7. prescription contraceptive diaphragms are covered but limited to one (1) per policy year;
8. expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
9. 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.
10. any expenses in excess of Usual and Reasonable charges except as provided in this Certificate.
11. loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
12. loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate, intramural or club sports
14. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;

15. 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 You are required to pay.
16. services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
17. expenses payable under any prior Certificate which was in force for the person making the claim.
18. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
19. expenses incurred after:
    - The date insurance terminates as to an Insured Person , except as specified in the extension of benefits provision; and
    - The end of the Policy Year specified in the Benefit Schedule.
20. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Certificate.
21. charges incurred for acupuncture, heat Treatment, diathermy, or massage, in any form, except to the extent provided in the Schedule of Benefits.
22. Surgery for removal of excess skin or fat.
23. charges for hair growth or removal unless otherwise specifically covered under the Certificate.
24. expenses for radial keratotomy, eye glasses or contact lenses except as required for repair caused by a Covered Injury office visit exam for the fitting of prescription contact lenses eyeglasses or duplicate spare eyeglasses or lenses or frames eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes or unless otherwise covered under the Pediatric and Adult Vision Care Benefit.
25. charges for hearing exams, hearing screening, hearing aids and the fitting or repair or replacement of hearing aids or cochlear implants except as specifically provided in the Certificate.
26. racing or speed contests skin diving or sky diving, mountaineering (where ropes or guides are customarily used)**,** ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
27. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical Treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    - For the purposes of this provision**, Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    - For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance or alter their personal concept of body image.
28. Treatment to the teeth, including orthodontic braces and orthodontic appliances, including surgical extractions of teeth .This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
29. elective abortions.
30. congenital defects, except as provided for newborn or adopted children added after the Effective Date of coverage.
31. Custodial Care service and supplies.
32. charges for hot or cold packs.
33. hernia, of any kind.
34. Services of a private duty Nurse.
35. expenses that are not recommended and approved by a Physician.
36. sexual reassignment surgery, except as provided when Medically Necessary or when Treatment is covered under the Certificate. This exclusion does not include related mental health counseling or hormone therapy.
37. routine harvesting and storage of stem cells from newborn the purchase price of any organ or tissue, donor services if the recipient is not an Insured Person under this plan, or services for or related to the transplantation of animal or artificial organs or tissues.
38. cosmetic procedures related to Gender Dysphoria including but not limited to face lift, facial bone reduction, lip enhancement or reduction, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
39. Sleep Disorders screening including testing.
40. Under the Prescription Drug Benefit shown in the Schedule of Benefits, any drug or medicine:
    - which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written, except as specifically provided in the Prescription Drug Benefit section of this plan;

- drugs with over-the-counter equivalents;
- Brand-Name Prescription Drugs with generic equivalents;
- allergy sera and extracts administered via injection;
- for the purpose of weight control;
- fertility drugs;
- vitamins, minerals, food supplements.;
- sexual enhancements drugs;
- dietary supplements;
- cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or Treatment of acne except as specifically provided in this Certificate;
- blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) prescription order per Policy Year;
- refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
- drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- purchased after coverage under the Certificate terminates;
- consumed or administered at the place where it is dispensed;
- if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- bulk chemicals;
- non-insulin syringes surgical supplies durable medical equipment/medical devices with the exception of diabetic blood monitors and kits;
- stimulants;
- repackaged products;
- blood components;
- immunology products.

41. non-chemical addictions.
42. non-physical, occupational, speech therapies (art, dance, etc.).
43. modifications made to dwellings.
44. general fitness, exercise programs.
45. hypnosis.
46. rolfing.
47. biofeedback.
48. hyperhidrosis.

Third Party Refund - When:

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

We are entitled to a refund by You of all Certificate benefits paid as a result of the Injury.

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

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

1. 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.
   a. Plan includes: group and nongroup insurance policies and subscriber 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; Medicare or any other federal governmental plan, as permitted by law; group and nongroup insurance policies and subscriber policies that pay or reimburse for the cost of dental care; and group and nongroup dental insurance policies and subscriber policies issued by a dental care corporation.
   b. 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 Certificate for coverage under a. or b. 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.

2. This plan means, in a COB provision, the part of the Certificate 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 Certificate providing health care benefits is separate from this plan. A Certificate 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.

3. 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.

4. Allowable expense is a health care expense, including Coinsurance or Copayments and without reduction for any applicable Deductible, that is covered in full or in part by any Plan covering the person. The amount of a reduction may be excluded from Allowable expense if an Insured Person's benefits are reduced under a Plan for either of the following reasons: Because the Insured Person does not comply with the Plan provisions concerning second surgical opinions or Pre-certification of admissions or services; or Because the Insured Person has a lower benefit because the Insured Person did not use a Preferred Provider. 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 You is not an Allowable expense.

   The following are examples of expenses that are not Allowable expenses:
   a. 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.
   b. 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.
   c. 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.
   d. 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 Certificate permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

e. The amount of any benefit reduction by the Primary plan because You failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, pre-certification of admissions, and preferred provider arrangements.

5. 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.

6. 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 Non-Preferred Provider benefits.

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

D. Each Plan determines its order of benefits using the first of the following rules that apply:
(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;

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

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
- The Plan covering the Custodial parent;
- The Plan covering the spouse of the Custodial parent;
- The Plan covering the non-custodial parent; and then
- The Plan covering the spouse of the non-custodial parent.

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

(d) For a dependent child covered under either or both parents' plans and is also covered as a dependent under his or her spouse's plan, the order of benefits is determined in the manner prescribed in paragraph (5) below. If the dependent child's coverage under his or her spouse's plan began on the same date as his or her coverage under either or both parents' plans, the order of benefits is determined by applying the birthday rule prescribed in Subparagraph (a) above to the dependent child's parents, as applicable, and his or her spouse.

(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 within 30 calendar days after receiving all of the information needed to pay the claim. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

SECTION VII - GENERAL PROVISIONS

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

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

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

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

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

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

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

Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

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

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

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

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

Illegal Occupation or Criminal Activity: We are not liable for any loss to which a contributing cause was the Insured Person's commission of or attempt to commit a felony or to which a contributing cause was the Insured Person's being engaged in an illegal occupation or other willful criminal activity.

Willful criminal activity includes, but is not limited to, any of the following:

a. Operating a vehicle while intoxicated in violation of section 625 of the Michigan vehicle code, 1949 PA 300, MCL 257.625, or similar law in a jurisdiction outside of this state.
b. Operating a methamphetamine laboratory. Methamphetamine laboratory means the site where the illegal manufacture of methamphetamine has taken place, and includes all equipment and supplies used at that site for that purpose.

Willful criminal activity does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

SECTION VIII - ADDITIONAL PROVISIONS

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

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

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

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

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

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

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

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

SECTION IX – APPEALS PROCEDURE

For purposes of this Section, the following definitions apply:

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

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

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

Internal Review Procedure

1. In the event of an Adverse Determination, We will notify You 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. You also had the right to contact the Director of Insurance or his or her office at any time.

   Department of Insurance and Financial Services
   530 West Allegan Street, 7th Floor
   P.O. Box 30220
   Lansing, MI 48909-7720
   (877) 999-6442

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. You do not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, You or Your 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 You 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 You within 30 days for a Prospective Review request or 60 days for a Retrospective Review request after receipt of the notice requesting the first level review.

   We shall provide free of charge to You, or Your 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 You, or Your authorized representative, a reasonable opportunity to respond prior to the date.

   Before We issue or provide notice of a final Adverse Determination that is based on new or additional rationale, We

shall provide the new or additional rationale to You, or Your 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 You, or Your authorized representative a reasonable opportunity to respond prior to the date.

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

Expedited reviews of grievances involving an Adverse Determination

We shall provide expedited review of a grievance involving an Adverse Determination with respect to concurrent review Urgent Care requests involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility. You or Your 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 You or, if applicable, Your authorized representative and Us by telephone, facsimile or the most expeditious method available. An expedited review decision shall be made and You or, if applicable, Your 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 You until You have been notified of the determination.

Patient's Right to Independent Review Act (PRIRA)

The PRIRA is a Michigan law that provides patients with appeal rights due to adverse decisions made by Us regarding a denial, reduction, or termination of health care services. The PRIRA external review process applies after You have exhausted Our internal grievance process. The PRIRA external review process does not apply to a medical provider's complaint concerning claims payment, handling or reimbursement for health care services. You are only eligible for the external review process if You have completed Our internal grievance process, or if you fail to complete the internal process (35 to 45 days).

You also have the right to bring a civil action in a court of competent jurisdiction. Note that You 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 Director.

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 You of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If You have 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 You clearly in writing or by electronic communication of Your right to request an external review at the time We send written notice of:
   a. An Adverse Determination upon completion of the Our utilization review process described above; or
   b. A final Adverse Determination.

   An external review may be requested within 120 days after You receive Our adverse benefit determination. The request needs to be accompanied by a signed authorization by You to release their medical records as necessary to conduct the external review.

2. An external review may be requested by You or Your authorized representative.

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 within 5 business days and if it is:
   a. Complete we will initiate the external review and notify You of:
      i. The name and contact information for the assigned independent review organization or the Director of Insurance, as applicable for the purpose of submitting additional information; and
      ii. A statement that You may submit, in writing, additional information for either the independent review organization or the Director 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 You or Your authorized representative in writing, including what information is needed to make the request complete. You or Your authorized representative shall provide the missing information within 30 days after receiving the notification for the request to continued. If the request is not accepted, You or Your authorized representative will receive written notice of the reasons for the nonacceptance.

5. We will not afford You an external review if:
   a. The Director of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   b. You failed to exhaust Our internal review process; or
   c. You previously were 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 You in writing:
   a. The reason for the denial; and
   b. That the denial may be appealed to the Director of Insurance.

6. For an expedited review: You or Your authorized representative may make a request for an expedited external review within 10 days 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 Your life or health if treated after the time frame of an expedited internal review.
   b. Your treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize Your life or health, or would jeopardize Your 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 You received Emergency Services, but has not yet been discharged from a facility.

7. You 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, You, a provider, health care facility rendering health care services to You, 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 You 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 You and all other parties involved with the decision by mail, or with the consent or approval of You, 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 You, the insurer and Your provider or the

health care facility if they requested the review. The written decision shall include a description of Your 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 Your Policy or Certificate.

External Review of Denial of Experimental or Investigative Treatment

Within one hundred twenty (120) days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination that involves a denial of coverage based on a determination that the health care service or Treatment recommended or requested is Experimental or Investigational, You or Your authorized representative may file a request for external review with the Director of Insurance.

You or Your authorized representative may make an oral request for an external review of the Adverse Determination or final Adverse Determination if Your 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 external review, the Director of Insurance immediately shall assign an independent review organization to conduct the review. The assigned independent review organization shall provide its recommendation to the Director of Insurance within 14 days after assignment. Upon receipt of a request for external review the Director of Insurance immediately shall notify and send a copy of the request to Us. Upon receipt of the assigned independent review organization's recommendation, the Director of Insurance immediately shall review the organization's recommendation to ensure that it is not contrary to the terms of coverage under the Policy. The Director of Insurance shall provide written notice to You or Your authorized representative and Us of the decision within 7 business days after the receipt of the organization's recommendation. If the Director of Insurance has kept a request for review, the Director shall provide written notice to You or Your authorized representative and Us of their decision within 14 days after the decision to keep the request.

Upon receipt of a request for an expedited external review, the Director of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Director 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 within 12 hours 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. The assigned independent review organization shall provide its recommendation to the Director of Insurance as expeditiously as Your medical condition or circumstances require, but not more than 36 hours after the date the Director received the request. Upon receipt of the assigned independent review organization's recommendation, the Director of Insurance immediately shall review the organization's recommendation to ensure that it is not contrary to the terms of coverage under the Policy. The Director of Insurance shall notify You or Your authorized representative and Us of the decision no later than 24 hours after the receipt of the organization's recommendation.

HIPAA Notice of Privacy Practices

of

COMMERCIAL CASUALTY INSURANCE COMPANY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective: June 01, 2017

This Notice of Privacy Practices (" Notice") applies to Commercial Casualty Insurance Company's (" we", "us" or " our") insured health benefits plan. We are required to provide you with this Notice.

Personal Information is information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage.

Protected Health Information (your "Health Information") is information that identifies you as related to your physical or mental health, your health care, or payment for your healthcare.

Our Responsibilities

We are required by law to maintain the privacy of the Health Information we hold and to provide you with this Notice and to follow the duties and privacy practices described in this Notice. We are required to abide by the terms of this Notice currently in effect.

We utilize administrative, technical, and physical safeguards to protect your information against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal rules pertaining to the security and confidentiality of your information.

We will promptly inform you if a breach has occurred that may have compromised the privacy or security of your Health Information.

Overview of this Notice

This Notice describes how certain information about you may be used and disclosed and how you can get access to this information. This Notice addresses three primary areas:

- An overview of Your Health Information. This section addresses how we collect your information, how we use it to run our business, and the reasons we share it.
- Your Rights. This section gives an overview of the rights you have with respect to your information we have in our records.
- How to Contact Us. In case you have any questions, requests, or even if you feel you need to make a complaint, we want to make sure you are in contact with the right person.

YOUR HEALTH INFORMATION

How We Acquire Your Information

In order to provide you with insurance coverage, we need Personal Information about you. Some of this information is collected from the school during the enrollment period. Other information comes to us from your health care provider, other insurers, third party administrators (TPAs), and your school's health center. This information is necessary to properly administer your health plan benefits.

How We use Your Health Information

Below are some examples of how we use and disclose your Health Information. Broadly, we will use and disclose your Health Information for Treatment, Payment and Health Care Operations.

Treatment refers to the health care treatment you receive. We do not provide treatment, but we may disclose certain information to doctors, dentists, pharmacies, hospitals, and other health care providers who will take care of you. For example, a doctor may send us information about your diagnosis and treatment so we can develop a health care plan and arrange additional services.

Payment refers to activities involving the collection of premiums, payment of claims, and determining covered services. For example, we may review your Health Information to determine if a particular treatment is medically necessary and what that payment for the services should be.

Health Care Operations refers to the business functions necessary for us to operate, such as audits, complaints responses and quality assurance activities. For example, we would use your Health Information (but not genetic information) for underwriting and calculating rates, or we may use your Health Information to detect and investigate fraud.

Additionally:

- We may **confirm enrollment** in this health plan with your school or to your school's consultant or your school's business partner.
- If you are a **dependent** of someone on the plan, we may disclose certain information to the plan's subscriber, such as an explanation of benefits for a service you may have received.
- Your school's health center may require enrollment information, payment information, or may require your Health Information to coordinate on-campus services you may need.

We may disclose your information when instructed to do so, including:

- **Health oversight activities** may require that we disclose your information to governmental, licensing, auditing and accrediting agencies;
- **Legal proceedings** may require disclosure of your Health Information in response to a court order or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other valid process;
- **Law enforcement activities** might require disclosure of certain Health Information to local, state or federal law enforcement, so long as the release is authorized or required by law;
- **As required by law** or to avert a serious threat to safety or health; and,
- To **certain government agencies**, such as the Department of health and Human Services or the Office of Civil Rights if they are conducting an investigation or audit.

Authorizations

Occasionally we may receive a request to share your information in a manner outside of how we normally use your Health Information, as described above. In those cases, we will ask you for your authorization before we share your Health Information.

YOUR RIGHTS

You have the **right to request restrictions** on certain uses and disclosures of your Health Information, including the uses and disclosures listed in this Notice and disclosures permitted by law. You also have the **right to request that we communicate with you in certain ways**.

- We will accommodate reasonable requests;
- We are not required to agree to a request to restrict a disclosure unless you have paid for the cost of the health care item or service in full (i.e., the entire sum for the procedure performed) and disclosure is not otherwise required by law; and,
- If you are a minor, depending on the state you reside in, you may have the right in certain circumstances to block parental access to your Health Information. For example, a minor would have the rights of an adult with respect to diagnosis and care of conditions such as STDs, drug dependency, and pregnancy.

You have the **right to inspect and copy your Health Information** in our records. Please note that there are exceptions to this, such as:

- Psychotherapy notes;
- Information complied in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
- Health Information that is subject to a law prohibiting access to that information; or,
- If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

We may deny your request to inspect and copy your Health Information if:

- A licensed health care professional has determined your requested access is reasonably likely to endanger your life or physical safety of another;
- The Health Information makes reference to another person and a licensed health care professional has determined that access requested is reasonably likely to cause substantial harm to another; or,
- A licensed health care professional has determined that access requested by your personal representative is likely to cause substantial harm to you or another person.

You have the **right to request an amendment** to your Health Information if you believe the information we have on file is incomplete or inaccurate. Your request must be in writing and must include the reason for the request. If we deny your request, you may file a written statement of disagreement.

You have the right to know who we have provided your information to - - this is known as an **accounting of disclosures**. A request for an accounting of disclosures must be submitted in writing to the address below. The accounting will not include disclosures made for treatment, payment, health care operations, for law enforcement purposes, or as otherwise permitted or required by law. If you request

an accounting of disclosures more than once in a twelve (12) month period we may charge a reasonable fee to process, compile and deliver the information to you this second time.

You have a **right to receive a paper copy of this Notice**. Simply call the customer service line indicated on your ID card and request a paper copy be mailed to you. You may also submit a written request to us at the address below.

You will receive a notice of a breach of your Health Information. You have the **right to be notified of a breach** of unsecure Health Information.

Finally, you have the **right to file a complaint** if you feel your privacy rights were violated. You may also file a complaint with the Secretary of Health and Human Services.

CONTACT

For all inquiries, requests and complaints, please contact:

Privacy and Security Officer Commercial Casualty
Insurance Company c/o Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104

This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of your Health Information we maintain, as well as any information we may receive or maintain in the future.

Please note that we do not destroy your Health Information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after our coverage terminates, although policies and procedures will remain in place to protect against inappropriate use and disclosure.

Gramm-Leach-Bliley ("GLB") Privacy Notice

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of *nonpublic personal information* ("NPI"). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING YOUR INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include your name, Social Security number, telephone number, address, date of birth, gender, work/school enrollment history, and health history. We may receive NPI from your completing the following forms:

- Claims forms
- Enrollment forms
- Beneficiary designation/Assignment forms
- Any other forms necessary to effectuate coverage, administer coverage, or administer and pay your claims

We also collect information from others that is necessary for us to properly process a claim, underwrite coverage, or to otherwise complete a transaction requested by a customer, policyholder or contract holder.

SHARING YOUR INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support organization such as a policyholder's or contract holder's broker, a third-party administrator, reinsurer, employer, school, or plan sponsor. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

HEALTH INFORMATION

We will not share any of your protected health information ("PHI") unless allowed by law, and/or you have provided us with the appropriate authorization. Additional information on how we protect your PHI can be found in the Notice of Privacy Practices.

SAFEGUARDING YOUR INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees or authorized individuals who need to know the NPI to provide insurance products or services to you. Our employees are continually trained on how to keep information safe.

ACCESSING YOUR INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our processing costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTING YOUR INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two (2) years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two (2) years.

CONTACTING US

If there are any questions concerning this notice, please feel free to write us at:

Privacy and Security Officer
Commercial Casualty Insurance Company
c/o Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104

NOTICE OF NON-DISCRIMINATION AND ACCESSIBIILITY REQUIREMENTS

The Company complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Company does not exclude people or treat them worse because of their race, color, national origin, age, disability, or sex.

The Company provides free aids and services to people with disabilities to communicate effectively with us, such as:

1. Qualified sign language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose first language is not English when needed to communicate effectively with us, such as:

1. Interpreters
2. information translated into other languages

If you need these services, contact Betsy M. Stevens and John Kelley Civil Rights Coordinators.

If you believe that Commercial Casualty Insurance Company has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Betsy M. Stevens and John Kelley Civil Rights Coordinators,
2077 Roosevelt Ave., Springfield, MA 01104
(413)-733-4540; (413)-733-4612
Bstevens@chpemail.com, or Jkelley@chpemail.com.

You can file a grievance in person, by mail, fax, or email. If you need help filing a grievance Betsy M. Stevens and John Kelley of Civil Rights Coordinators are available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:
U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F, HHH Building
Washington, DC 20201
800-8681019; 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

The Company complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ADVISORY NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT'S OFFICE OF FOREIGN ASSETS CONTROL ("OFAC")

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning possible impact on your insurance coverage due to the directives issued by OFAC and possibly by the U.S. Department of State. **Please read this Policyholder Notice carefully.**

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy on Presidential declarations of "National Emergency". OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers

as *Specially Designated Nationals* and *Blocked Persons.* This list can be found on the U.S. Department of Treasury's website (www.treas.gov/ofac)

In accordance with OFAC regulations, or any applicable regulation promulgated by the U.S. Department of State, if it is determined that you or another insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is identified by OFAC as a *Specially Designated National* or *Blocked Person*, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.

LANGUAGE ASSISTANCE PROGRAM

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Please call (877) 657-5030.

ATENCIÓN: Si habla **español (Spanish)**, hay servicios de asistencia de idiomas, sin cargo, a su disposición. Llame al (877) 657-5030.

請注意：如果您說中文 **(Chinese)**，我們免費為您提供語言協助服務。請致電：(877) 657-5030.

XIN LƯU Ý: Nếu quý vị nói tiếng **Việt (Vietnamese)**, quý vị sẽ được cung cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Vui lòng gọi (877) 657-5030.

알림: 한국어**(Korean)**를 사용하시는 경우 언어 지원 서비스를 무료로 이용하실 수 있습니다. (877) 657-5030번으로 전화하십시오.

PAUNAWA: Kung nagsasalita ka ng **Tagalog (Tagalog)**, may makukuha kang mga libreng serbisyo ng tulong sa wika. Mangyaring tumawag sa (877) 657-5030.

ВНИМАНИЕ: бесплатные услуги перевода доступны для людей, чей родной язык является **русском (Russian)**. Позвоните по номеру (877) 657-5030.

ةيبرعلا ثدحتت تنك اذإ :هيبنت **(Arabic)**، بـ لـاصتلأا ءاجرلا .كلـ ةحاتم ةيناجملا ةيوغللا ةدعاسملا تامدخ نإف 657-5030 (877).

ATANSYON: Si w pale **Kreyòl ayisyen (Haitian Creole)**, ou kapab benefisye sèvis ki gratis pou ede w nan lang pa w. Tanpri rele nan (877) 657-5030.

ATTENTION : Si vous parlez **français (French)**, des services d'aide linguistique vous sont proposés gratuitement. Veuillez appeler le (877) 657-5030.

UWAGA: Jeżeli mówisz po **polsku (Polish)**, udostępniliśmy darmowe usługi tłumacza. Prosimy zadzwonić pod numer (877) 657-5030.

ATENÇÃO: Se você fala **português (Portuguese)**, contate o serviço de assistência de idiomas gratuito. Ligue para (877) 657-5030.

ATTENZIONE: in caso la lingua parlata sia l'**italiano (Italian)**, sono disponibili servizi di assistenza linguistica gratuiti. Si prega di chiamare il numero (877) 657-5030.

ACHTUNG: Falls Sie **Deutsch (German)** sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufen Sie (877) 657-5030 an.

注意事項：日本語 **(Japanese)** を話される場合、無料の言語支援サービスをご利用いただけます。(877) 657-5030 にお電話ください。

یسراف امشد نابز رگا :هجوت **(Farsi)** دشاب یم امشد رایتخا رد نامگیار روط هب ینابز دادما تامدخ ،تسا.
(877) 657-5030 تمسا بیگرید.

कृपा ध्या द□: य□द आप **□हंद□ (Hindi)** भाषी ह□ तो आपके □लए भाषा सहायता सेवाएं□न:शुल् उपलब् ह□। कृपा पर काल कर□ (877) 657-5030

CEEB TOOM: Yog koj hais Lus **Hmoob (Hmong)**, muaj kev pab txhais lus pub dawb rau koj. Thov hu rau (877) 657-5030.

ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ**(Khmer)** សេវាកម្មភាសាជំនួយឥតគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរស័ព្ទមកលេខ (877) 657-5030 ។

PAKDAAR: Nu saritaem ti **Ilocano (Ilocano)**, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Maidawat nga awagan iti (877) 657-5030.

DÍÍ BAA'ÁKONÍNÍZIN: **Diné (Navajo)** bizaad bee yániłti'go, saad bee áka'anída'awo'ígíí, t'áá jíík'eh, bee ná'ahóót'i'. T'áá shoodí kohjį' (877) 657-5030 hodíilnih.

OGOW: Haddii aad ku hadasho **Soomaali (Somali)**, adeegyada taageerada luqadda, oo bilaash ah, ayaad heli kartaa. Fadlan wac (877) 657-5030

ગુજરાતી (Gujarati) ચુ ના: જો તમે જરાતી બોલતા હો, તો િન:લ્કુ ભાષા સહાય સેવાઓ તમારા માટ ઉપલબ્ધ છ. ફોન કરો (877) 657-5030

λληνικά (Greek)ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε (877) 657-5030

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (877) 657-5030

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ(877) 657-5030

ਪੰਜਾਬੀ (Punjabi) ਧਆਨ ਦਿਓ: ਜੇ ਤੁਸ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ (877) 657-5030

ພາສາລາວ (Lao) ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (877) 657-5030