2018–2019 Student Health Insurance Plan

DREW UNIVERSITY / MADISON NJ

Policy No. 2018D5A12
Effective 8/15/18–8/15/19

Drew University—Graduate Students

Madison, NJ

Serviced by:

University Health Plans
a Division of Risk Strategies
15 Pacella Park Drive
Randolph, MA 02368
Phone: (800) 437-6448
Fax: (617) 472-6419
www.universityhealthplans.com

Claims Administered by:

CHP Student HEALTH
2077 Roosevelt Avenue
Springfield, MA 01104
877-657-5030
Email: customerservice@consolidatedhealthplan.com
www.chpstudenthealth.com

Underwritten by:

NGL
It's about people.

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

As Policy Form No. NBH-280 (2018) NJ

18-D5A12 (Cert.)

WHERE TO FIND HELP	
For Questions About:	**Please Contact:**
Health Services	**Drew University Health Services** 36 Madison Ave Madison, NJ 07940 (973) 408-3414 **Health@drew.edu or visit our website at www.drew.edu/health**
Servicing Broker	**University Health Plans** 15 Pacella Park Drive Randolph, MA 02368 800-437-6448 **www.universityhealthplans.com**
Insurance Benefits Preferred Provider Listings Claims Processing ID Card Requests	**Consolidated Health Plans** 2077 Roosevelt Avenue Springfield, Massachusetts 01104 877-657-5030 **www.chpstudenthealth.com**
Preferred Provider Listings	**Cigna PPO** **www.Cigna.com**
Prescription Drug Providers	**Cigna PBM** **www.Cigna.com**

EFFECTIVE DATES AND COSTS		
	Annual **8/15/18 – 8/15/19**	**Spring/Summer** **1/15/19 – 8/15/19**
Student*	$4,579	$2,681

*The above rates include an administrative fee.

The Policy is renewed as a new Policy for the term August 15, 2018 to August 15, 2019 as Policy Number 2018D5A12. All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

IMPORTANT INFORMATION FROM DREW UNIVERSITY

Drew University requires all full-time college students to carry medical insurance. Students should enroll or waive the insurance plan before arriving on campus in the Fall, please see page 13 of this document for instructions to do this. Students will automatically be billed for this plan through Drew's Student Accounts Office should they fail to submit a waiver application. The Fall waiver is an annual waiver; only new students may enroll in the Spring semester.

All residential students and intercollegiate and recreational athletes are strongly encouraged to enroll in the student insurance plan whenever possible, since many family insurance plans have restrictions on out-of-area providers or may not pay for non-emergency services when away from home (even in NJ). The following student insurance plan has no restrictions on providers whether at home, on vacation, or at Drew. This plan gives students options for local referrals, and covers most billable services on campus.

Most medical and wellness services can be obtained on- campus at our nationally accredited University Health Service. Students are not charged for routine sick visits, wellness counseling or psychological services at Drew. However, our staff will refer students to off-site specialists or the emergency room when needed, and students are responsible for related charges. Students who are not covered by the student insurance plan are responsible for obtaining pre-authorization for specialist or hospital care.

The health insurance plan described in this brochure has been designed to complement the services that are available on-campus, and will provide coverage for eligible expenses for off-campus referrals or Hospitalizations. Students enrolled in this insurance plan will not be billed for allergy shots, laboratory tests, and well-woman services that are obtained on campus (except international travel advisory/vaccines). This plan will meet the needs of most students. Optional plans for new graduate continuation coverage are also available.

Call University Health Plans directly for more information (877) 657-5030, or contact them at: www.universityhealthplans.com.

DREW UNIVERSITY HEALTH SERVICES

Students do not have to enroll in the student insurance plan in order to receive care at the Drew University Health Service.

On-campus services include:

- Alcohol / drug information
- Allergy shots
- Assessment and treatment of acute illnesses
- Diagnostic tests in on-site lab or outside lab

- Eating disorder care / information
- Gynecological care
- Health education programs
- Immunizations including flu shots
- International travel advisory/vaccines
- Management of chronic disease or disability
- Medications available on-site (discounted)
- Nutrition counseling
- Physical exams (discounted fees apply)
- Pregnancy testing
- Referrals to specialists as needed
- Sexually transmitted infection testing/treatment
- X-Ray and mammogram referral to local facility

Health Service Hours: (regular semesters)
Monday - Thursday 9 AM – 8 PM
Friday 9 AM – 5 PM
Saturday 10 AM – 2 PM
Sunday 2 PM
Limited hours during January & summers

For more information about on-campus services contact:

Drew University Health Service
36 Madison Avenue
Madison, NJ 07940
(973) 408-3414 health@drew.edu
Or visit our website at www.drew.edu/health

Please read this certificate carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, University Health Plans at 800-437-6448, or the Administrative Agency Consolidated Health Plans at 877-657-5030.

COVERAGE

1. Accident and Sickness coverage begins on August 15, 2018, or the date of enrollment in the plan, whichever is later and ends August 15, 2019 (Policy Year).
2. Benefits are payable during the Policy Year, subject to any Extension of Benefits.
3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Year for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.
4. The Policy provides benefits based on the type of health care provider the Insured Student selects. This Certificate provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

This Certificate includes a Pre-certification provision.

CERTIFICATE OF
STUDENT GROUP HEALTH INSURANCE

issued by

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

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

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2018) NJ ("the Policy"). This Certificate is governed by the state of New Jersey.

Table of Contents

Section 1 — Definitions

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

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

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

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.

Autism means Autism and related conditions often included under the phrase "Autism Spectrum Disorder." In current clinical terms, this would include several conditions classified under "Pervasive Developmental Disorder." For the purposes of this benefit Autism includes Childhood Disintegrative Disorder (CDD) and Rhett's Disorder.

Brand Name Drugs means a prescription drug whose manufacture and sale is controlled by a single company as a result of a patent or similar right.

Certified Pedorthist means a person certified by the American Board for Certification in Pedorthics, or its successor, in the design, manufacture, fit and modification of shoes and related foot appliances from the ankle and below as prescribed by a licensed doctor of medicine or podiatric medicine for the amelioration of painful or disabling conditions of the foot; and "foot appliances" includes, but is not limited to, prosthetic fillers and orthotic appliances for use from the ankle and below.

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

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

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

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

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

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

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

1. Not in excess of the PPO Allowance for Treatment, services, or supplies that are received from Network Providers;
2. Not in excess of the Usual and Reasonable charges if such Treatment, services, or supplies are received from Non-Network providers;
3. Not in excess of the charges that would have been made in the absence of this insurance; and
4. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

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

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

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

Developmental Disability as defined in the New Jersey Developmentally Disabled Rights Act means a severe, chronic disability of a person which: 1. is attributable to a mental or physical impairment or combination of mental or physical impairments; 2, is manifested before age 22; 3, is likely to continue indefinitely; 4, results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and 5. reflects the need for a combination and sequence of special inter-disciplinary or generic care, Treatment or other services which are of lifelong or extended duration and are individually planned and coordinated. Developmental Disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met.

Domestic Student means a permanent resident of the United States who is enrolled at the School.

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

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

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

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay-person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: 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 a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: 1. there is inadequate time to effect a safe transfer to another hospital before delivery; or 2. the transfer may pose a threat to the health or safety of the woman or the unborn child.

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 means benefits that are defined as such by the Secretary of Labor in the following general categories, and the items and services covered within the categories:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral 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.

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

Formulary means a list of prescription drugs that are preferred for use under the Policy through lower cost sharing or other financial incentives. A formulary may have multiple tiers. A Policy that provides benefits for all Brand Name Drugs at one level of cost sharing and for all Generic Drugs at another level of cost sharing is not considered a Formulary.

Generic Drugs means any prescription drug which is not a Brand Name Drug.

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

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

Hospital means an institution that: 1. Operates as a Hospital pursuant to law; 2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients; 3. Provides 24-hour nursing service by Registered Nurses on duty or call; 4. Has a staff of one or more Physicians available at all times; and 5. Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis. Hospital does not include the following: 1. Convalescent homes or convalescent, rest or nursing facilities; 2. Facilities primarily affording custodial, educational, or rehabilitory care; or 3. Facilities for the aged, drug addicts or alcoholics.

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

Immediate Family Member means the Insured Student and his or her Spouse or Domestic Partner or the parent, child, brother or sister of the Insured Student or his or her Spouse or Domestic Partner.

Infertility means the disease or condition that results in the abnormal function of the reproductive system such that a person is not able to: 1. Impregnate another person; 2. Conceive after two years of unprotected intercourse if the female partner is under 35 years of age or one year of unprotected intercourse if the female partner is 35 years of age or older or one of the partners is considered medically sterile; or 3. Carry a pregnancy to live birth.

Inherited Metabolic Disease means a disease caused by an inherited abnormality of body chemistry for which testing is mandated pursuant to New Jersey law.

Insured Person means You while insured under the Policy.

Insured Student means a student who is eligible for coverage and is insured under the Policy.

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

Licensed Orthotist means any person who practices orthotics and who represents himself to the public by title or by description of services, under any title incorporating such terms as “orthotics,” “orthotists,” “orthotic,” or “L.O.” or any similar title or description of services, provided that the individual has met the eligibility requirements contained in N.J.S.A. 45:12B-11 and is licensed pursuant to N.J.S.A. 45128-13.

Licensed Prosthetist means a person who practices prosthetics and who represents himself to the public by title or by description of services, under any title incorporating such terms as “prosthetics,” “prosthetist,” “prosthetic.” or “L.P.” or any similar title or description of services, provided that the individual has met the eligibility requirements contained in N.J.S.A. 45:12B-11 and is licensed pursuant to N.J.S.A. 45:12B-13.

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

Low Protein Modified Food Product means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein.

Medical Food means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and is formulated to be consumed or administered enterally under direction of a Physician.

Medical Necessity or Medically Necessary means or describes a health care service that a Physician, exercising his or her prudent clinical judgment, would provide to an Insured Person for the purpose of evaluating, diagnosing, or treating a Covered Sickness, Covered Injury, disease, or its symptoms and that is: 1. in accordance with the generally accepted standards of medical practice; 2. clinically appropriate, in terms of type, frequency, extent, site, and duration; 3. considered effective for the Insured Person ‘s Covered Sickness, Covered Injury, or disease; 4. not primarily for the convenience of the Insured Person or the Physician ; and 5. 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 Covered Sickness, Covered Injury, or disease.

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

Network Provider means a Physician, Hospital, and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Non-Network Provider means Physicians, Hospitals, and other healthcare providers who have not agreed to any pre-arranged fee schedules.

Orthotic Appliance means a brace or support but does not include fabric and elastic supports, corsets, arch supports, trusses, elastic hose, canes, crutches, cervical collars, dental appliances or other similar devices carried in stock and sold by drug stores, department stores, corset shops or surgical supply facilities.

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

Physician means a: 1. Doctor of Medicine (M.D.); or 2. Doctor of Osteopathy (D.O.); or 3. Doctor of Dentistry (D.M.D. or D.D.S.); or 4. Doctor of Chiropractic (D.C.); or 5. Doctor of Optometry (O.D.); or 6. Doctor of Podiatry (D.P.M.); who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered. A Doctor of Psychology (Ph.D.) will also

be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also mean any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a registered nurse, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician. The term Physician does not mean any person who is an Immediate Family Member.

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

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

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

Prosthetic Appliance means any artificial device that is not surgically implanted and that is used to replace a missing limb, appendage, or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs, or other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

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

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.

Spouse means a lawful spouse or civil union partner of an Insured Student according to New Jersey law. Spouse does not include a Domestic Partner.

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

Student Health Center or Student Infirmary means an on campus facility that provides: 1. Medical care and treatment to Sick or Injury students; and 2. Nursing services. A Student Health Center or Student Infirmary does not include: 1. Medical, diagnostic and treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or 2. Inpatient care.

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.

Telehealth means the use of information and communications technologies such as telephone, remote patient monitoring devices, or other electronic means to support clinical health care.

Telemedicine means the delivery of a health care service using electronic communication, information technology, or other electronic or technological means between a Physician and an Insured Person who are not located at the same site. Telehealth does not include the use of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

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

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

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

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

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

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

Section 2 – Eligibility, Enrollment and Termination

Drew University is making available a Student Health Insurance program underwritten by National Guardian Life Insurance Company and administered by Consolidated Health Plans. This certificate provides a summary of the insurance coverage. Keep this certificate as no individual policy will be issued. The Master Policy will be available for review upon request.

Matriculated students (accepted in a degree granting program) who are at least part-time, or those who have completed coursework and are registered for maintaining matriculation status, are eligible to purchase the plan. Matriculated students who are not currently registered, or who have requested a leave of absence, are not eligible to enroll in the plan.

Students enrolled exclusively in online courses and whose enrollment consists entirely of short-term courses are not eligible to enroll in the plan. Be aware that if eligible students waive their right to purchase this insurance or do not enroll by the deadline, they will not be able to enroll again until the following year. Only new students are eligible to enroll in January.

Students must be physically and actively attending classes on campus for at least the first thirty-one (31) days beginning with the first day for which coverage is purchased.

Students on a leave of absence, or not currently registered for coursework are not eligible to enroll.

Home study, correspondence, internet, and television (TV) courses do not fulfill the Eligibility requirements.

The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

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

Extension of Benefits: Coverage under the Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows: 1. If an Insured Person is Totally Disabled due to Covered Injury or Covered Sickness, We will continue to cover Treatment for the Covered Injury or Covered Sickness causing the Total Disability for 12 months from the Termination Date; and 2. Regarding expenses incurred for a covered pregnancy, We will continue to cover expenses incurred or services or supplies are provided in connection with maternity resulting from conception prior to the Termination Date.

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

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

Continuation of Coverage Following Death of the Insured Student: If a covered Dependent's insurance would otherwise terminate due to the death of the Insured Student, his or her coverage may continue, subject to payment of the appropriate premium, for 180 days after the death of the Insured Student. Continuation is not available with respect to Insured Persons whose coverage terminates for reasons other than the death of the Insured Student.

Section 3 – BENEFITS

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

Pre-Certification Process

You are responsible for notifying the claims administrator at the phone number found on the Your ID card to begin the Pre-certification process. For inpatient benefits or surgery, the call must be made at least 5 working days before Hospital Confinement or surgery.

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

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

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

Your Physician will be notified of Our decision as follows:
1. For non-urgent admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the approved number of inpatient days;
2. For confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact the claims administrator before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone;

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

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

Please see the Appeals section for information regarding Prospective Reviews. Failure by the claims administrator to make a determination within the time periods prescribed shall be deemed an Adverse Determination subject to an appeal.

You should contact Your Physician with questions about any Pre-certification status.

Medical Management

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

Preventive Services

The following services shall be covered without regard to any Deductible, Copayment, or Coinsurance requirement that would otherwise apply: 1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force; 2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved; 3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in item 1 above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Essential Health Benefits

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

Treatment of Covered Injury or Covered Sickness

We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person due to a Covered Injury or Covered Sickness. Benefits payable are subject to: 1) Any specified benefit maximum amounts; 2) Any Deductible amounts; 3) Any Coinsurance amount; 4) Any Copayments; 5) The Maximum Out-of-Pocket Expense Limit.; 6) the Exclusions and Limitations provision.

Out-of-Pocket Expense Limit

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

Preferred Provider Organization

If an Insured Person uses a Network Provider, the benefit amount payable under this Certificate will be the Coinsurance percentage of the PPO Allowance shown in the Schedule of Benefits for Covered Medical Expenses. If is the Insured Person's responsibility to pay any Copayment, his or her Coinsurance percentage, and any Deductible.

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

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

1. There is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider, benefits will be paid at the PPO Allowance level. Covered medical expense incurred for services provided by a Non-Network Provider during a Hospital Inpatient confinement at a Network Provider Hospital will be paid at the PPO Allowance level of benefits.
3. An Insured Person's liability for services rendered during a hospitalization in a Network hospital, including, but not limited to, anesthesia and radiology, where the admitting physician is a network provider and the Insured Person and/or provider has complied with all required preauthorization or notice requirements, shall be limited to the copayment, deductible and/or coinsurance applicable to Network services; and
4. That a covered person's liability for services rendered during a hospitalization in a Network hospital, including, but not limited to Anesthesia and radiology, where the admitting physician is a Non-Network Provider, shall be limited to the Copayment, Deductible and/or Coinsurance applicable to Network services.

We will not calculate benefits for services provided by Non Network Providers by using negotiated fees agreed to by Network Providers.

An Insured Person should be aware that it is important to verify that his or her Physicians are Network Providers each time he or she calls for an appointment or at the time of service.

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

1. On the date of occurrence of such Covered Injury; or
2. From the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of the Policy Term (+ Extension of Benefits – when appropriate).

SCHEDULE OF BENEFITS		
We offer a PPO Provider Network as healthcare delivery system for your health plan. You may utilize the services of Network and Non-Network Providers. This Schedule of Benefits describes important things about your health insurance plan, like your benefit limits and your Network and Non-Network cost-sharing amounts for the Covered Services you will receive during the Policy Year (the 12-month period that begins on the effective date of your coverage). Please read this Certificate of Coverage, Schedule of Benefits and any Benefit Riders for complete coverage details, benefit limitations and exclusions.		
Preventive Services Network Provider: 100% of PPO Allowance for Covered Services Non-Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Usual and Reasonable Charge.		
Deductible Network: $300 Individual Non-Network: $300 Individual		
Out-of-Pocket Expense Limit Network: Individual $6,350 Non-Network: No Maximum		
Coinsurance Amount Network: 80% of PPO Allowance for Covered Medical Expenses unless otherwise stated Non-Network: 70% of Usual and Reasonable Charge (U&R) for Covered Medical Expenses unless otherwise stated		
Inpatient Benefits		
BENEFITS FOR COVERED INJURY/SICKNESS	NETWORK	NON-NETWORK
Hospital Room & Board Expenses Pre-certification required	The PPO Allowance stated above	The U&R Charge stated above
Hospital Intensive Care Unit Expense - *in lieu of normal Hospital Room & Board Expenses* Pre-certification required	The PPO Allowance stated above	The U&R Charge stated above
Hospital Miscellaneous Expenses for services & supplies	The PPO Allowance stated above	The U&R Charge stated above
Preadmission Testing	The PPO Allowance stated above	The U&R Charge stated above
Physician's Visits while Confined:	The PPO Allowance stated above	The U&R Charge stated above
Inpatient Surgery: Precertification required Surgeon Services Anesthetist Assistant Surgeon	 The PPO Allowance stated above 25% of benefits payable for Surgeon Services The PPO Allowance stated above	 The U&R Charge stated above 25% of benefits payable for Surgeon Services The U&R Charge stated above
Physical Therapy (inpatient) Precertification required	The PPO Allowance stated above	The U&R Charge stated above
Extended Care Facility Expense Benefit for non-custodial care	The PPO Allowance stated above	The U&R Charge stated above
Skilled Nursing Facility Benefit Precertification required	The PPO Allowance stated above	The U&R Charge stated above

Bariatric Surgery Precertification required	The PPO Allowance stated above	The U&R Charge stated above
Mental Health Disorder Precertification required	Same as any other Covered Sickness	Same as any other Covered Sickness
Substance Use Disorder Precertification required	Same as any other Covered Sickness	Same as any other Covered Sickness
Outpatient Benefits	NETWORK	NON-NETWORK
BENEFITS FOR COVERED INJURY/ SICKNESS		
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 The PPO Allowance stated above 25% of benefits payable for Surgeon Services The PPO Allowance stated above	 The U&R Charge stated above 25% of benefits payable for Surgeon Services The U&R Charge stated above
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxy-gen tent, and blood & plasma	The PPO Allowance stated above	The U&R Charge stated above
Physical Therapy (outpatient)	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Emergency Services Expenses	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense
In Office Physician's Fees	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Diagnostic X-ray Services Includes MRI and tomography	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Laboratory Procedures (Outpatient)	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Mental Health Disorder	Same as any other Covered Sickness	Same as any other Covered Sickness
Substance Use Disorder	Same as any other Covered Sickness	Same as any other Covered Sickness
Prescription Drugs (Copay based on 30 day supply) In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	100% of PPO Allowance for Covered Medical Expenses Copayment: $15.00. In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense Generic Copayment: $30.00 Preferred Brand Copayment: $50.00 Brand	100% of U&R Charge for Covered Medical Expenses Copayment: $15 Generic Copayment: $30 Preferred Brand Copayment: $50 Brand *Paid on a reimbursement basis*

Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Hospice Care Coverage	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Urgent Care Center or Facility	The Coinsurance Amount stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy Habilitative services are covered to the extent that they are Medically Necessary	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expenses	The U&R Charge stated above
Other Benefits	NETWORK	NON-NETWORK
BENEFITS FOR COVERED INJURY/ SICKNESS		
Ambulance Service – Ground and/or Air Transportation	The PPO Allowance stated above	The U&R Charge stated above
Braces and Appliances including Prosthesis and Orthotics	The PPO Allowance stated above	The U&R Charge stated above
Durable Medical Equipment	The PPO Allowance stated above	The U&R Charge stated above
Maternity Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Routine Newborn Care	Same as any other Covered Sickness	Same as any other Covered Sickness
Consultant Physician Services	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Accidental Injury Dental Treatment for Insured Person's over age 18	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Sickness Dental Expense for Insured Persons over age 18	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Student Health Center/Infirmary Expense	100% of U&R Charge for Covered Medical Expenses	
Abortion Expense	No Benefit	No Benefit
Bedside Visits (International Students and/or their Dependents Only)	100% of U&R Charge for Covered Medical Expenses Subject to $5,000.00 maximum per Policy Year	
Medical Treatment Received in Home Country (International Students and/or their Dependents Only)	70% of U&R Charge for Covered Medical Expenses	
Medical Evacuation Expense	100% of U&R Charge for Covered Medical Expenses	
Repatriation Expense	100% of U&R Charge for Covered Medical Expenses	

Routine Eye Exams (Adult) Eye screenings provided as part of a routine physical exam	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The PPO Allowance stated above
Chiropractic Care	The PPO Allowance stated above	The U&R Charge stated above
Pediatric Vision Care Benefit Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames	100% of PPO Allowance for Covered Medical Expenses	The U&R Charge stated above *for Preventive Services*
Pediatric Dental Care Benefit Preventive Pediatric Dental Care limited to 1 dental exam every 6 months *The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:* Diagnostic and Restorative Endodontic, Periodontal, Prosthodontic Oral and Maxillofacial Surgical Orthodontic Treatment For all other service supplies	See Benefit for limitations 100%, No Deductible, Copayment, or Coinsurance will be applied to Preventive Care when services received in Network Coinsurance Amount 100% 50% 50% 50%	See Benefit for limitations The U&R Charge stated above for Preventive Services Coinsurance Amount 100% 50% 50% 50%
Mandated Benefits for New Jersey		
BENEFITS FOR COVERED INJURY/ SICKNESS	NETWORK	NON-NETWORK
Infant Formulae Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Audiology and Speech Language Pathology Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Therapeutic Treatment of Inherited Metabolic Disease Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Dental Treatment for the Severely Disabled or Children Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Hemophilia Treatment Expense Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Orthotic or Prosthetic Appliances Benefit	Same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule	Same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule
Screening for Newborn Hearing Loss Benefit	Same as any other Covered Sickness (This benefit is not subject to a Deductible)	Same as any other Covered Sickness (This benefit is not subject to a Deductible)
Home Health Care Benefit	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Treatment of Wilm's Tumor Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Mastectomy and Reconstructive Breast Surgery Benefit	The PPO Allowance stated above In all cases, the benefit amount will be 50% or more of the aggregate risk for Covered Medical Expense	The U&R Charge stated above
Treatment of Diabetes Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Lead Screening for Children	Same as any other Covered Sickness	Same as any other Covered Sickness
Mammography Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Digital Tomosynthesis Insured Persons age 40 and over Insured Persons under age 40	 100% of PPO Allowance for Covered Services 100% of PPO Allowance	 100% of U&R Charge for Covered Medical Expenses 100% of U&R Charge for Covered Medical Expenses

Donated Human Breast Milk	The PPO Allowance stated above	The U&R Charge stated above
Diagnosis and Treatment of Infertility	Same as any other Covered Sickness	Same as any other Covered Sickness
Registered Nurse First Assistant	Paid on the same basis as Assistant Surgeon	Paid on the same basis as Assistant Surgeon
Hearing Aid Expense	Same as any other Covered Sickness	Same as any other Covered Sickness
Oral Anticancer Medication	Same as any other Prescription Drug	Same as any other Prescription Drug
Sickle Cell Diagnosis and Treatment	Same as any other Covered Sickness	Same as any other Covered Sickness
Prostate Screening Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Telehealth/Telemedicine	Same as any other Covered Sickness	Same as any other Covered Sickness
MUST OFFER BENEFIT(S) FOR NEW JERSEY		
Treatment of Cancer; Bone Marrow Transplants Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness

Inpatient Benefits

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

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

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

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

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

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

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

Extended Care Facility Expense Benefit for expenses incurred for the services, supplies and treatments rendered to an Insured Person by an Extended Care Facility. The Insured Person must enter an Extended Care Facility: 1. Within 14 days after his/her discharge from a Hospital confinement; 2. Such confinement must be of at least three (3) consecutive days that began while coverage was in force under the Policy; and 3. Was for the same or related Sickness or Accident. Services, supplies and treatments by an Extended Care Facility include: 1. Charges for room, board and general nursing services; 2. Charges for physical, occupational or speech therapy; 3. Charges for drugs, biologicals, supplies, appliances and equipment for use in such facility, which are ordinarily furnished by the Extended Care Facility for the care and treatment of a confined person; and 4. Charges for medical services of interns, in training, under a teaching program of a Hospital with which the facility has an agreement for such services.

Skilled Nursing Facility Benefit for confinement in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for custodial care or residential care is not covered, except as rendered as part of Hospice Care. As used in this benefit Skilled Nursing Facility means 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 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.

Bariatric Surgery for covered medical expenses incurred for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health for the long term reversal of Morbid Obesity. We will pay these expenses on the same basis as for other medical and surgical procedures.

For the purpose of this coverage, Morbid Obesity means a body mass index that is greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a high risk comorbid condition. Body mass index is calculated by dividing the weight in kilograms by the height in meters squared.

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.

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

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

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

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

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

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

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

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

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.

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.

Prescription Drugs –

1. We will pay the expenses incurred for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made.
2. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, provides benefits for expenses incurred in prescribing a drug for a treatment for which the drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed: a. in one of the following established reference compendia: the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; the United States Pharmacopoeia Drug Information; or b. it is recommended by a clinical study or review article in a major peer-reviewed professional journal. Coverage is not provided for any experimental or investigational drug or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Benefits also include Medically Necessary services associated with the administration of the drug.
3. This benefit also covers the purchase of prescription female contraceptives on the same basis as other outpatient prescription drugs. Prescription female contraceptives includes any drug or device used for contraception by a female Insured Person, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in New Jersey with a prescription written by a Physician licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. A religious School may request, and We shall grant, an exclusion under the Policy for female contraceptives if the benefit conflicts with the religious schools bona fide religious beliefs and practices. The School shall provide written notice thereof to prospective Insured Persons and Insured Persons. A religious School is an elementary, secondary school, college or university that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C. § 3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. § 501(c)(3).
4. We will provide coverage for expenses incurred for refills of Prescription eye drops if:
   a. The prescribing Health Care Provider indicates on the original prescription that additional quantities of the prescription eye drops are needed; and
   b. The refill requested by the Insured Person does not exceed the number of additional quantities indicated on the original prescription from the Health Care Provider.
5. Synchronization of prescribed medications. Once per policy year, per Insured Person, we will:
   a. Apply a prorated daily cost-sharing rate to prescriptions for less than a 30 day supply if the or pharmacist indicates the fill or refill is in the best interest of the Insured Person or is to synchronize the Insured Person's chronic medications;
   b. Provide coverage for a drug prescribed for treatment of chronic illness dispensed according to a plan among the Health Care Provider, the Insured Person, and the pharmacist to synchronize the refill of multiple prescriptions for the Insured Person; and
   c. Determine the dispensing fees based exclusively on the total number of prescriptions dispense. Dispensing fees will not be prorated or based on the number of days' supply of medication prescribed or dispensed.

   This synchronization of prescribed medications does not apply to Opioid Analgesics. Opioid Analgesics means drug in the Opioid Analgesic drug class prescribed to treat moderate pain or other conditions. Such drug may be in immediate or extended release form, whether or not combined with other drugs to form a single drug product or dosage form.

6. Non-Formulary drugs are considered Medically Necessary if:
   a. The drug is approved under the Federal Food, Drug and Cosmetic Act, 21 U.S.C. 301 et seq. or the drug's use is recognized as medically appropriate for treatment for which the drug has been prescribed in one of the following: American Hospital Formulary Service Drug Information; the United States Pharmacopoeia – Drug Information; or the drug is recommended by a clinical study or review article in a major peer-reviewed professional journal.
   b. The prescribing Physician states that all Formulary drugs used to treat each phase of the disease have been ineffective in the treatment of the disease or condition or all such drugs have caused or are reasonably expected to cause adverse or harmful reactions in the Insured Person.
   c. We will respond via telephone or other telecommunication device within one business day to a request for prior authorization made by a prescribing Physician. If We do not respond within one day, the request will be deemed approved. We will provide an initial denial of a request within five business days of receipt of the request. Our denial will include a clinical reason for the denial. The Insured Person and/or the Physician may appeal the denial.
   d. The current Formulary list and/or list of Non-Formulary Drugs are available to You upon request.
7. Approval process for Non-Formulary drugs. You are responsible for notifying the claims administrator at the phone number found on the Your ID card to begin the prior authorization process. Your Physician will be notified of Our decision via telephone within one business day of the request. If We do not respond within one day, the request will be deemed approved. If the request is denied, we will provide a written response within five business days. The written response will include a clinical reason for the denial of the request. You have the right to appeal a denial of a request. Please see the Appeals section of this Certificate.
8. We will not restrict or prohibit a pharmacy from charging for additional services provided for the drug, dispensing the drug, or prescription counseling. The pharmacy must disclose to You the charges for any additional services and the out-of-pocket cost for those services before dispensing the drug. The pharmacy cannot impose any additional charges for patient counseling or for other services required by the New Jersey Board of Pharmacy or state or federal law.

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.

Hospice Care Coverage for Hospice Care when You require such care as the result of Covered Injury or Covered Sickness. You must have been diagnosed with a terminal illness by a licensed Physician. Your 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. As used in this benefit:

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

Other Benefits

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

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

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

Maternity Benefit - We will pay the expenses incurred for maternity charges as follows: 1. Hospital stays for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals. 2. Inpatient Physician charges or surgeon charges will be covered the same as for any other Covered Sickness for both mother and newborn child. 3. Physician-directed Follow-up Care including: a) Physician assessment of the mother and newborn; b) Parent education; c) Assistance and training in breast or bottle feeding; d) Assessment of the home support system; d) Performance of any prescribed clinical tests; and e) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals. This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "a", the home health care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn. 4. Outpatient Physician's visits will be covered the same as for any other Covered Sickness.

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

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

Accidental Injury Dental Treatment - As the result of injury. Routine dental care and Treatment are not payable under this benefit.

Sickness Dental Expense Benefit - If, by reason of sickness, an Insured Person requires Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred for the Treatment.

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

Bedside Visits (International Students and/or their Dependents Only) - If the Insured Person is Hospital Confined for more than seven (7) continuous days as the result of a Covered Injury or Covered Sickness, We will pay a benefit. We will pay for the cost of an economy round-trip airfare for an individual to travel to the Hospital bedside of the Insured Person. The benefit will not to exceed the amount shown in the Schedule of Benefits. This individual must be designated by the Insured Person and the trip must be approved by Us. No more than one trip may be made during any one Policy Year.

Medical Treatment Received in Home Country (International Students and/or their Dependents Only) - If the Insured Person incurs expenses as the result of treatment for a Covered Injury or Covered Sickness in his or her Home Country, we will pay the expenses incurred not to exceed the amount shown in the Schedule of Benefits.

Medical Evacuation and Repatriation - To be eligible for this benefit, a Student must: a) be an International Student enrolled in the authorized College or School during the period for which coverage is purchased. or b) be a Eligible Domestic Student participating in a study abroad program sponsored by the College or School. An eligible International Student must meet the definition of same. An International Student may also enroll his or her Dependent under this Section by payment of additional premium. As used in this Section, an Eligible Domestic Student means a permanent resident of the United States who is enrolled at the College or School and who is temporarily participating in international educational activities outside their Home Country. The maximum combined benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits.

Medical Evacuation Expense – If an Insured Student is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness that occurs while he or she is covered under the Policy, We will pay the necessary Usual and Reasonable Expenses for evacuation to another medical facility or the Insured Person's 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: 1. The Insured Person 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; 2. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation; 3. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable; 4. No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person's insurance terminates. However, if on the date of termination, the Insured Person is 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; 5. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and 6. Transportation must be by the most direct and economical route.

Repatriation Expense - If the Insured Person dies while he or she is covered under the Policy, 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 the Insured Person's place of residence in his or her Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Routine Eye Exams (Adult) for an eye examination as may be included in a physical examination.

Chiropractic Care Benefit for chiropractic care as described in the Schedule of Benefits.

Pediatric Vision Care Benefit if any Insured Person is age 18 or under:

1. one comprehensive vision examination by an ophthalmologist or optometrist in a 12 month period;
2. One pair of standard lenses, for glasses or contact lenses, in a 12 month period;
3. one pair of standard frames in a 12 month period. "Standard frames" refers to frames that are not designer frames, such as Coach, Burberry, Prada or other designers.

Pediatric Dental Care Benefit if any Insured Persons is age 18 or under. This benefit is subject to: (1) the Deductible in the Schedule of Benefits; and (2) the following Coinsurance Amounts:

SERVICE	COINSURANCE AMOUNT
Diagnostic and Restorative	100%
Endodontic, Periodontal, Prosthodontic, Oral and Maxillofacial Surgical	50%
Orthodontic Treatment	50%
For all other services and supplies	50%

We provide benefits for Diagnostic Services, Preventive Services, Restorative Services, Endodontic Services, Periodontal Services, Prosthodontic Services, Oral and Maxillofacial Surgical Services, Orthodontic Services and certain Adjunctive General Services, as described in this Certificate. These Services are subject to the following:

- Dental services are available from birth with an age one dental visit encouraged. A second opinion is allowed.
- Emergency treatment is available without prior authorization. Emergency treatment includes, but may not be limited to treatment for: pain, acute or chronic infection, facial, oral or head and neck injury, laceration or trauma, facial, oral or head and neck swelling, extensive, abnormal bleeding, fractures of facial bones or dislocation of the mandible.
- Diagnostic and preventive services are linked to the provider, thus allowing a member to transfer to a different provider/practice and receive these services. The new provider is encouraged to request copies of diagnostic radiographs if recently provided. If they are not available radiographs needed to diagnose and treat will be allowed.
- Denials of services to the dentist shall include an explanation and identify the reviewer including their contact information. Services with a dental laboratory component that cannot be completed can be considered for prorated payment based on stage of completion.
- Unspecified services for which a specific procedure code does not exist can be considered with detailed documentation and diagnostic materials as needed by report.
- Services that are considered experimental in nature will not be considered.
- This Certificate will not cover any charges for broken appointments.

Diagnostic Services

* Indicates diagnostic services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

1. Clinical oral evaluations once every 6 months *
   a. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation;
   b. Periodic oral evaluation – subsequent thorough evaluation of an established patient*;
   c. Oral evaluation for patient under the age of 3 and counseling with primary caregiver*;
   d. Limited oral evaluations that are problem focused;
   e. Detailed oral evaluations that are problem focused.
2. Diagnostic Imaging with interpretation:
   a. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views;
   b. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit;
   c. Additional films/views needed for diagnosing can be provided as needed;
   d. Bitewings, periapicals, panoramic and cephlometric radiographic images;
   e. Intraoral and extraoral radiographic images;
   f. Oral/facial photographic images;
   g. Maxillofacial MRI, ultrasound;
   h. Cone beam image capture.
3. Tests and Examinations.
4. Viral culture.
5. Collection and preparation of saliva sample for laboratory diagnostic testing.
6. Diagnostic casts – for diagnostic purposes only and not in conjunction with other services.
7. Oral pathology laboratory:
   a. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report;
   b. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report;
   c. Other oral pathology procedures, by report.

Preventive Services

* Indicates preventive services that can be considered every 3 months for individuals with special healthcare needs are denoted with an asterisk.

1. Dental prophylaxis once every 6 months*.
2. Topical fluoride treatment once every 6 months – in conjunction with prophylaxis as a separate service*.
3. Fluoride varnish once every 3 months for children under the age of 6.
4. Sealants, limited to one time application to all occlusal surfaces that are unfilled and caries free, in premolars and permanent molars.
5. Space maintainers – to maintain space for eruption of permanent tooth/teeth, includes placement and removal:
   a. fixed – unilateral and bilateral;
   b. removable – bilateral only;
   c. recementation of fixed space maintainer;
   d. removal of fixed space maintainer – considered for provider that did not place appliance.

Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure after insertion may require documentation to demonstrate material failure as the cause.

- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing or restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for occlusal restoration includes any extensions onto the occlusal one-third of buccal, facial, or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered.

Restorative service to include:

1. Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
2. Gold foil - . Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
3. Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
4. Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
   a. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion;
   b. Provisional crowns are not covered.
5. Re-cement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
6. Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.
7. Core buildup including pins h) Pin retention.
8. Indirectly fabricated (custom fabricated/cast) and prefabricated post and core.
9. Additional fabricated (custom fabricated/cast) and prefabricated post.
10. Post removal.
11. Temporary crown (fractured tooth).
12. Additional procedures to construct new crown under existing partial denture.
13. Coping.
14. Crown repair.
15. Protective restoration/sedative filling.

Endodontic Services

- Service includes all necessary radiographs or views needed for endodontic treatment.
- Teeth must be in occlusion, periodontically sound, needed for function and have good long term prognosis.
- Service will not be considered for teeth that are not in occlusion or function and have poor long term prognosis.

Endodontic service to include:

1. Therapeutic pulpotomy for primary and permanent teeth.
2. Pulpal debridement for primary and permanent teeth.
3. Partial pulpotomy for apexogenesis.
4. Pulpal therapy for anterior and posterior primary teeth.
5. Endodontic therapy and retreatment.
6. Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation.
7. Apexification: initial, interim and final visits.
8. Pulpal regeneration.
9. Apicoectomy/Periradicular Surgery.
10. Retrograde filling.
11. Root amputation.
12. Surgical procedure for isolation of tooth with rubber dam.
13. Hemisection.
14. Canal preparation and fitting of preformed dowel or post.
15. Post removal.

Periodontal Services

1. Surgical services:
   a. Gingivectomy and gingivoplasty;
   b. Gingival flap including root planning;
   c. Apically positioned flap;
   d. Clinical crown lengthening;
   e. Osseous surgery;
   f. Bone replacement graft – first site and additional sites;
   g. Biologic materials to aid soft and osseous tissue regeneration;

h. Guided tissue regeneration;
i. Surgical revision;
j. Pedicle and free soft tissue graft;
k. Subepithelial connective tissue graft;
l. Distal or proximal wedge;
m. Soft tissue allograft;
n. Combined connective tissue and double pedicle graft.

2. Non-Surgical Periodontal Service:
   a. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma;
   b. Periodontal root planing and scaling – every 6 months for individuals with special healthcare needs;
   c. Full mouth debridement to enable comprehensive evaluation;
   d. Localized delivery of antimicrobial agents.
3. Periodontal maintenance.

Prosthodontic Services

- New dentures or replacement dentures may be considered every 7 ½ years unless dentures become obsolete due to additional extractions or are damaged beyond repair.
- All needed dental treatment must be completed prior to denture fabrication.
- Patient identification must be placed in dentures in accordance with State Board regulation.
- Insertion of dentures includes adjustments for 6 months post insertion.
- Prefabricated dentures or transitional dentures that are temporary in nature are not covered.

Prosthodontic services to include:

1. Complete dentures and immediate complete dentures – maxillary and mandibular to address masticatory deficiencies. Excludes prefabricated dentures or dentures that are temporary in nature
2. Partial denture – maxillary and mandibular to replace missing anterior tooth/teeth (central incisor(s), lateral incisor(s) and cuspid(s)) and posterior teeth where masticatory deficiencies exist due to fewer than eight posterior teeth (natural or prosthetic) resulting in balanced occlusion.
   a. Resin base and cast frame dentures including any conventional clasps, rests and teeth;
   b. Flexible base denture including any clasps, rests and teeth;
   c. Removable unilateral partial dentures or dentures without clasps are not considered;
3. Overdenture – complete and partial.
4. Denture adjustments –6 months after insertion or repair.
5. Denture repairs – includes adjustments for first 6 months following service.
6. Denturerebase – following 12 months post denture insertion, denture rebase is covered and includes adjustments for first 6 months following service.
7. Denture relines – following 12 months post denture insertion denture relines are covered once a year and includes adjustments for first 6 months following service.
8. Precision attachment, by report.
9. Maxillofacial prosthetics - includes adjustments for first 6 months following service:
   a. Facial moulage, nasal, auricular, orbital, ocular, facial, nasal septal, cranial, speech aid, palatal augmentation, palatal lift prosthesis – initial, interim and replacement;
   b. Obturator prosthesis: surgical, definitive and modifications;
   c. Mandibular resection prosthesis with and without guide flange;
   d. Feeding aid;
   e. Surgical stents;
   f. Radiation carrier;
   g. Fluoride gel carrier;
   h. Commissure splint;
   i. Surgical splint;
   j. Topical medicament carrier;
   k. Adjustments, modification and repair to a maxillofacial prosthesis;
   l. Maintenance and cleaning of maxillofacial prosthesis;
10. Implant Services – are limited to cases where facial defects and or deformities resulting from trauma or disease result in loss of dentition capable of supporting a maxillofacial prosthesis or cases where documentation demonstrates lack of retention and the inability to function with a complete denture for a period of two years. Covered services include: implant body, abutment and crown.
11. Fixed prosthodontics (fixed bridges) – are selective and limited to cases with an otherwise healthy dentition with unilateral missing tooth or teeth generally for anterior replacements where adequate space exists:
    a. The replacement of an existing defective fixed bridge is also allowed when noted criteria are met;
    b. A child with special health needs that result in the inability to tolerate a removable denture can be considered for a fixed bridge or replacement of a removable denture with a fixed bridge;
    c. Considerations and requirements noted for single crowns apply;

d. Posterior fixed bridge is only considered for a unilateral case when there is masticatory deficiency due to fewer than eight posterior teeth in balanced occlusion with natural or prosthetic teeth;
e. Abutment teeth must be periodontally sound and have a good long term prognosis;
f. Repair and recementation.

12. Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth.

Oral and Maxillofacial Surgical Services

Local anesthesia, suturing and routine post op visit for suture removal are included with service.

1. Extraction of teeth:
   a. Extraction of coronal remnants – deciduous tooth;
   b. Extraction, erupted tooth or exposed root;
   c. Surgical removal of erupted tooth or residual root;
   d. Impactions: removal of soft tissue, partially boney, completely boney and completely bony with unusual surgical complications.
2. Extractions associated with orthodontic services must not be provided without proof that the orthodontic service has been approved.
3. Other surgical Procedures:
   a. Oroantral fistula;
   b. Primary closure of sinus perforation and sinus repairs;
   c. Tooth reimplantation of an accidentally avulsed or displaced by trauma or accident;
   d. Surgical access of an unerupted tooth;
   e. Mobilization of erupted or malpositioned tooth to aid eruption;
   f. Placement of device to aid eruption;
   g. Biopsies of hard and soft tissue, exfoliative cytological sample collection and brush biopsy;
   h. Surgical repositioning of tooth/teeth;
   i. Transseptal fiberotomy/supra crestal fiberotomy;
   j. Surgical placement of anchorage device with or without flap;
   k. Harvesting bone for use in graft(s.)
4. Alveoloplasty in conjunction or not in conjunction with extractions.
5. Vestibuloplasty.
6. Excision of benign and malignant tumors/lesions.
7. Removal of cysts (odontogenic and nonodontogenic) and foreign bodies.
8. Destruction of lesions by electrosurgery.
9. Removal of lateral exostosis, torus palatinus or torus madibularis.
10. Surgical reduction of osseous tuberosity.
11. Resections of maxilla and mandible - Includes placement or removal of appliance and/or hardware to same provider.
12. Surgical Incision:
    a. Incision and drainage of abcess - intraoral and extraoral;
    b. Removal of foreign body;
    c. Partial ostectomy/sequestrectomy;
    d. Maxillary sinusotomy.
13. Fracture repairs of maxilla, mandible and facial bones – simple and compound, open and closed reduction. Includes placement or removal of appliance and/or hardware to same provider.
14. Reduction of dislocation and management of other temporomandibular joint dysfunctions (TMJD), with or without appliance. Includes placement or removal of appliance and/or hardware to same provider.
    a. Reduction - open and closed of dislocation. Includes placement or removal of appliance and/or hardware to same provider;
    b. Manipulation under anesthesia;
    c. Condylectomy, discectomy, synovectomy;
    d. Joint reconstruction.
15. Arthrotomy, arthroplasty, arthrocentesis and non-arthroscopic lysis and lavage.
16. Arthroscopy.
17. Occlusal orthotic device – includes placement and removal to same provider.
18. Surgical and other repairs:
    a. Repair of traumatic wounds – small and complicated;
    b. Skin and bone graft and synthetic graft;
    c. Collection and application of autologous blood concentrate;
    d. Osteoplasty and osteotomy;
    e. LeFort I, II, III with or without bone graft;
    f. Graft of the mandible or maxilla – autogenous or nonautogenous;
    g. Sinus augmentations;
    h. Repair of maxillofacial soft and hard tissue defects;
    i. Frenectomy and frenoplasty;

j. Excision of hyperplastic tissue and pericoronal gingiva;
k. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula;
l. Emergency tracheotomy;
m. Coronoidectomy;
n. Implant – mandibular augmentation purposes;
o. Appliance removal – "by report" for provider that did not place appliance, splint or hardware.

Orthodontic Services

Medical necessity must be met by demonstrating severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in functional difficulties or documentation of a psychological/psychiatric diagnosis from a mental health provider that orthodontic treatment will improve the mental/psychological condition of the child.

- Orthodontic treatment is not considered for cosmetic purposes.
- Orthodontic consultation can be provided once annually as needed by the same provider.
- Pre-orthodontic treatment visit for completion of the HLD (NJ-Mod2) assessment form and diagnostic photographs and panoramic radiograph/views is required for consideration of services.
- Orthodontic cases that require extraction of permanent teeth must be approved for orthodontic treatment prior to extractions being provided. The orthodontic approval should be submitted with referral to oral surgeon or dentist providing the extractions and extractions should not be provided without proof of approval for orthodontic service.
- Initiation of treatment should take into consideration time needed to treat the case to ensure treatment is completed prior to 19th birthday.
- Periodic oral evaluation, preventive services and needed dental treatment must be provided prior to initiation of orthodontic treatment.
- The placement of the appliance represents the treatment start date.
- Reimbursement includes placement and removal of appliance. Removal can be requested by report as separate service for provider that did not start case.
- Completion of treatment must be documented to include diagnostic photographs and panoramic radiograph/view of completed case and submitted when active treatment has ended and bands are removed. Date of service used is date of band removal.

Orthodontic service to include:

1. Limited treatment for the primary, transitional and adult dentition.
2. Interceptive treatment for the primary and transitional dentition.
3. Minor treatment to control harmful habits.
4. Continuation of transfer cases or cases started outside of the program.
5. Comprehensive treatment for handicapping malocclusions of adult dentition. Case must demonstrate medical necessity based on score total equal to or greater than 26 on the HLD (NJ-Mod2) assessment form with diagnostic tools substantiation or total scores less than 26 with documented medical necessity.
6. Orthognathic Surgical Cases with comprehensive orthodontic treatment.
7. Repairs to orthodontic appliances.
8. Replacement of lost or broken retainer.
9. Rebonding or recementing of brackets and/or bands.

Request for treatment must include diagnostic materials to demonstrate need, the completed HDL (NJ-Mod2) form and documentation that all needed dental preventive and treatment services have been completed.

Approval for comprehensive treatment is for up to 12 visits at a time with request for continuation to include the previously mentioned documentation and most recent diagnostic tools to demonstrate progression of treatment.

Adjunctive General Services

1. Palliative treatment for emergency treatment – per visit.
2. Anesthesia:
   a. Local anesthesia NOT in conjunction with operative or surgical procedures;
   b. Regional block;
   c. Trigeminal division block;
   d. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by this Certificate which requires hospitalization or general anesthesia. 2 hour maximum time;
   e. Intravenous conscious sedation/analgesia – 2 hour maximum time;
   f. Nitrous oxide/analgesia;
   g. Non-intravenous conscious sedation – to include oral medications.
3. Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
   - One unit equals 15 minutes of additional time.
   - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded:;
     - Office or Clinic maximum – 2 units;
     - Inpatient/Outpatient hospital – 4 units;
     - Skilled Nursing/Long Term Care – 2 units.

4. Consultation by specialist or non-primary care provider.
5. Professional visits:
   - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
   - Hospital or ambulatory surgical center call:
     - For cases that are treated in a facility;
     - For cases taken to the operating room –dental services are provided for patient with a medical condition covered by this Certificate which requires this admission as in-patient or out-patient. Prior authorization is required;
     - General anesthesia and outpatient facility charges for dental services are covered;
     - Dental services rendered in these settings by a dentist not on staff are considered separately.
   - Office visit for observation – (during regular hours) no other service performed.
6. Drugs:
   - Therapeutic parenteral drug:
     - Single administration;
     - Two or more administrations - not to be combined with single administration.
   - Other drugs and/or medicaments – by report.
7. Application of desensitizing medicament – per visit.
8. Occlusal guard – for treatment of bruxism, clenching or grinding.
9. Athletic mouthguard covered once per year.
10. Occlusal adjustment:
    - Limited – (per visit):
    - Complete (regardless of the number of visits), once in a lifetime.
11. Odontoplasty.
12. Internal bleaching.

Mandated and Must Offer Benefits for New Jersey

The following benefits are mandated and must offer coverage's in the State of New Jersey. Mandates will be included in all School plans issued under the Policy as required. Must offers will be included if selected by the Policyholder. Unless specified otherwise, all such coverage will be subject to any Deductible, Copayment and Coinsurance conditions of the Policy as well as all other terms and conditions applicable to any other Covered Sickness.

Mandated Benefits for New Jersey:

Infant Formulae - When an issued policy covers the expenses incurred in the purchase of prescription drugs, coverage will also be provided for the expenses incurred in the purchase of specialized non-standard infant formulas, if the plan includes coverage for Dependent Children. The covered infant's Physician must have diagnosed the infant as having multiple food protein intolerance. The Physician must determine such formula to be Medically Necessary when the covered infant has not been responsive to trials to standard non-cow milk based formulas, including soybean and goat milk. We will pay the expenses incurred for such formulas to the same extent as for any other prescribed items under the policy.

Audiology and Speech Language Pathology - We will pay for expenses incurred as the result of a Covered Injury or Covered Sickness for audiology and speech language pathology services. Such services must be determined by a Physician to be Medically Necessary and must be performed or rendered to an Insured Person by a licensed audiologist or speech language pathologist within the scope of his or her practice.

Therapeutic Treatment of Inherited Metabolic Diseases - We will pay expenses incurred for the therapeutic Treatment of Inherited Metabolic Diseases, including the purchase of medical foods and Low Protein Modified Food Products, when diagnosed and determined to be Medically Necessary by the Insured's Physician.

Treatment of Cancer; Bone Marrow Transplants - We will pay for expenses incurred for the Treatment of cancer by: 1. dose intensive chemotherapy; 2. autologous bone marrow transplants; and/or 3. peripheral stem cell transplants.

Such Treatments must be performed by an institution approved by the National Cancer Institute or pursuant to protocols consistent with guidelines of the American Society of Clinical Oncologists.

Dental Treatment for the Severely Disabled or Children - We will pay for expenses incurred for: 1 general anesthesia and Hospitalization for dental services; or 2. a medical condition covered by the Policy which requires Hospitalization or general anesthesia for dental services rendered by a dentist regardless of where the dental services were performed. This benefit is limited to Treatment of an Insured Person who is severely disabled or to a covered Dependent child age five (5) or under.

Hemophilia Treatment Expense - We will pay for expenses incurred in connection with the Treatment of routine bleeding episodes associated with hemophilia will be covered under Policy on the same basis as any other Covered Sickness. We will also pay the expenses incurred in connection with the purchase of blood products and blood infusion equipment required for home Treatment of routine bleeding episodes associated with hemophilia. The home Treatment program must be under the supervision of a New Jersey approved hemophilia Treatment center. Participation in a home Treatment program will not preclude further or additional Treatment or care at any eligible facility if the number of home visits does not exceed the total number of benefit days provided for any other Covered Sickness.

Orthotic or Prosthetic Appliances Benefit - We will pay the Usual and Reasonable expenses incurred in obtaining an orthotic or Prosthetic Appliance from any licensed orthotist or prosthetist, or any certified Pedorthist, as determined Medically Necessary by the Insured Person's Physician. Reimburse

for orthotic and Prosthetic Appliances will be at the same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule. Benefits will be provided to the same extent as for any other medical condition under the policy.

Screening for Newborn Hearing Loss - When the Policy includes Dependent Coverage, we will provide screening for newborns by appropriate electrophysiologic screening measures and periodic monitoring of infants for delayed onset of hearing Loss. Benefits will be provided to the same extent as for any other medical condition under the policy, except that no Deductible may be applied for benefits provided under this provision. Note: Payment for this screening service shall be separate and distinct from payment for routine new baby care in the form of a newborn hearing screening fee and no Deductible shall be applied.

Home Health Care Benefit - We will pay benefits for the following Covered Medical Expenses when the Insured Person requires Home Health Care. Covered Expenses under this benefit are limited to the following: 1 Home Health Care Visits - We will pay for expenses incurred for Home Health Care Visits; and 2. Other Home Health Care Services - We will pay the charges for other Home Health Care Services, as defined, not to exceed the amount the Policy would have paid if the Insured Person had been Hospitalized.

Treatment Wilm's Tumor - We will pay for expenses incurred in the Treatment of Wilm's tumor to the same extent as for any other Covered Sickness. This Treatment will include an autologous bone marrow transplant when standard chemotherapy Treatment is unsuccessful, notwithstanding that any such Treatment may be considered experimental or investigational.

Mastectomy and Reconstructive Breast Surgery - We will pay for expenses incurred for up to 72 hours of inpatient care following a modified radical mastectomy. We will also cover reconstructive breast surgery to the same extent as for any other Covered Sickness. The benefits under this provision include, but are not limited to: 1. the costs of prostheses; and 2. if the coverage issued to the Policyholder provides outpatient x-ray or radiation therapy, the cost of outpatient chemotherapy following surgical procedures in connection with the Treatment of breast cancer will be included as part of the outpatient x-ray or radiation therapy coverage.

Treatment of Diabetes - We will pay for the following services, supplies, and Treatment: 1. Equipment and Supplies – for expenses incurred if an Insured incurs expenses for any of the following equipment and supplies used in the Treatment of diabetes: a) blood glucose monitors and blood glucose monitors for the legally blind; b) data management systems; c) test strips for glucose monitors and visual reading and urine testing strips; d) insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and e) appurtenances thereto; f) insulin infusion devices; and oral agents for controlling blood sugar.

Self-Management Education for Diabetes - We will pay the charges incurred for diabetes self-management education that is necessary to ensure that the Insured is educated as to the proper self-management and Treatment of their diabetic condition, including information on proper diet. This benefit is limited to visits that are Medically Necessary upon: 1. the diagnosis of diabetes; 2. diagnosis of a significant change in the Insured Person's symptoms or conditions that necessitate changes in the Insured's self-management; and 3. the determination that reeducation or refresher education is necessary. Diabetes self-management education will be provided by a dietician registered by a nationally recognized professional association of dieticians or a health care professional recognized as a Certified Diabetes Educator by the American Association of Diabetes Educators or a registered pharmacist in the state qualified with regard to management education for diabetes by any institution recognized by the board of pharmacy of the State of New Jersey.

Lead Poisoning Screenings for Children - If coverage for Dependent children is provided under the policy, We will pay the charges for: 1. screening by blood lead measurement for lead poisoning for children, including confirmatory blood lead testing as specified by the Department of Health; and 2. medical evaluation and any necessary medical follow-up and Treatment for lead poisoned children. Benefits will be provided to the same extent as for any other medical condition under the policy, except that no Deductible may be applied for benefits provided under this provision.

Mammography Benefit - We will pay the charges for expenses incurred in conducting:

1. one baseline mammogram examination for female Insured Persons who are 40 years of age; a mammogram examination every year for female Insured Persons age 40 and over; and, in the case of a female Insured Person woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed Medically Necessary by the woman's Physician; and
2. An ultrasound evaluation, magnetic resonance imaging scan, three-dimensional mammography, or other testing of an entire breast or breasts, after a baseline mammogram examination, if:
    a. The mammogram shows extremely dense breast tissue; or
    b. The mammogram is abnormal with any degree of breast density including not dense, moderately dense, heterogeneously dense, or extremely dense breast tissue; or
    c. The Insured Person has additional risk factors for breast cancer, including but not limited to family history of breast cancer, prior personal history of breast cancer, positive genetic testing, extremely dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology, or other indications as determined by the Insured Person's Physician.

If benefits are also payable under the Preventive Services Benefit, We will pay under only one benefit, the more favorable benefit.

Digital Tomosynthesis – We will pay expenses incurred for digital tomosynthesis conducted to screen for breast cancer for female Insured Persons who are age 40 or over, no cost-sharing applied. If the test is conducted for a female Insured Person under age 40, the cost sharing applied will be the same as any other Covered Service.

Donated Human Breast Milk – We will pay for expenses incurred in the provision of pasteurized donated human breast milk, which may include human milk fortifiers if prescribed by a Physician, if:

1. the Insured Person is an infant under six months of age;
2. the milk is obtained from a human milk bank that meets quality guidelines developed by the new Jersey Department of Health; and
3. a Physician has issued an order for an infant who is medically or physically unable to receive maternal breast milk or participate in breast feeding or whose mother is medically or physically unable to produce breast milk in sufficient quantities or participate in breast feeding despite optimal lactation support; or
4. A Physician has issued an order for an infant who meets any of the following conditions:
   a. Body weight below healthy levels as determined by the Physician;
   b. A congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis; or
   c. A congenital or acquired condition that may benefit from the use of donor breast milk as determined by the New Jersey Department of Health.

No benefits are payable if there is no available supply of human breast milk that meets the requirements listed above.

Diagnosis and Treatment of Infertility: We will pay the Medically Necessary expenses incurred for the diagnosis and Treatment of Infertility. Such coverage includes, but is not limited to the following services related to Infertility: 1. Diagnosis and diagnostic tests; 2, Medications; 3. Surgery; 4. In vitro fertilization; 5. Embryo transfer; 6. Artificial insemination;7. Gamete intra fallopian transfer; 8. Zygote intra fallopian transfer; 9. Intracytoplasmic sperm injection.

Coverage for items 4, 7, and 8 is limited to an Insured Person who: 1. has used all reasonable, less expensive and medically appropriate Treatments and is still unable to become pregnant or carry a pregnancy; 2. has not reached the limit of four completed egg retrievals; and 3. is 45 years of age or younger. Benefits will be provided to the same extent as for other pregnancy-related procedures under the Policy, except that services provided for under this provision must be performed at facilities that conform to the standards established by the American Society for Reproductive Medicines or the American College of Obstetricians and Gynecologists. The same Copayments, Deductibles and benefit limits will apply to the diagnosis and Treatment of Infertility as those applied to other medical or surgical benefits under the policy. A Religious School may request an exclusion for in-vitro fertilization, embryo transfer, artificial insemination, zygote intra fallopian transfer and intracytoplasmic sperm injection if the required coverage is contrary to the employer's bona fide religious tenets. We will issue the Policy to such Religious School with an exclusion attached. We will provide written notice to each person insured under the Policy. For the purposes of this benefit, Religious School means School, College, or university that is operated, supervised or controlled by or in connection with a church or a convention or association or churches.

Registered Nurse First Assistant - When the Policy includes Surgery coverage, We will also pay the expenses incurred for the services of a Registered Nurse First Assistant who is operating within the scope of his or her license. We will pay the expenses incurred on the same basis as if they were performed by an Assistant Surgeon when required by the surgeon performing a surgical procedure.

Hearing Aid Expense - We will provide coverage for Medically Necessary expenses incurred in the purchase of a hearing aid for an Insured under age 16 when prescribed or recommended by a licensed Physician or audiologist. We will pay up the benefit amount shown in the Schedule of Benefits. An Insured Person may choose a hearing aid that is priced higher than the benefit payable under this benefit and pay the difference between the hearing aid and the benefit payable.

Oral Anticancer Medication - We will pay a benefit for Usual and Reasonable expenses incurred for prescribed, orally administered anticancer medication that has been approved by the Federal Food and Drug Administration and is used to kill or slow the growth of cancerous cells. Coverage will be provided at a cost to the Insured Persons not to exceed the Coinsurance percentage or Copayment amount, if any, as it is applied to intravenously-administered or an injected cancer medication prescribed for the same purpose.

Sickle Cell Anemia - We will pay benefits for expenses incurred by an Insured for the Treatment of sickle cell anemia on the same basis as any other Covered Sickness. If the policy provides coverage for expenses incurred in the purchase of outpatient prescription drugs, We shall provide coverage for prescription drug expenses incurred by the Insured for the Treatment of sickle cell anemia.

Prostate Screening Benefit - We will pay benefits for expenses incurred by an Insured Person for conducting an annual medically recognized diagnostic examination including, but not limited to, a digital rectal examination and a prostate-specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. If benefits are also payable under the Preventive Services Benefit, We will pay under only one benefit, the more favorable benefit.

Telehealth/Telemedicine – We will pay benefits for health care services delivered to the Insured Person through Telehealth or Telemedicine on the same basis as services delivered through in-person contact.

Section 4 – 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 Act. The policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the policy and as shown in the Schedule of Benefits.

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 the Insured Person could be eligible.
2. preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.
3. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as provided in the Schedule of Benefits.
4. dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to Your Sound, Natural Teeth.
5. professional services rendered by an Immediate Family Member or any who lives with the Insured Person.

6. services or supplies not necessary for the medical care of an Injury or Sickness except as specifically covered under any of the preventive benefits provided under the Policy.
7. services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury or except as specifically provided under the Policy.
8. weak, strained, or flat feet, corns, calluses or ingrown toenails.
9. treatment or removal of acne or sleep disorders including the testing for same.
10. expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
11. 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.
12. any expenses in excess of Usual and Reasonable charges.
13. 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.
14. loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Insurance Information Schedule.
15. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any intercollegiate,intramural or club sports.
16. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sports;
17. treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
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 the Insured Person.
20. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Policy.
22. expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the Policy.
23. expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a Covered Injury.
24. 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.
25. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery. 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 and Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance).
26. an Insured Person's: a) committing or attempting to commit a felony; b) being engaged in an illegal occupation, or c. participation in a riot.
27. elective abortions.
28. custodial care service and supplies.
29. expenses that are not recommended and approved by a Physician.

Section 5 – CERTIFICATE PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

Section 6 – Coordination of Benefits

If the Insured Person is insured under more than one group health plan, the benefits of the plan that covers the Insured Student as an Insured Person but not a Dependent will be used before those of a plan that provides coverage as a Dependent. When both parents have group health plans that provide coverage as a Dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers' Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy on file with the Policyholder

COORDINATION OF THIS POLICY'S BENEFITS AND SERVICES WITH OTHER

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

Purpose Of This Provision: An Insured Person may be covered for health benefits or services by more than one Plan. For instance, he or she may be covered by this Policy as an Insured Student and by another Plan as a Dependent of his or her Spouse or Domestic Partner. If he or she is covered by more than one Plan, this provision allows Us to coordinate what We pay or provide with what another Plan pays or provides. This provision sets forth the rules for determining which is the primary Plan and which is the secondary Plan. COB is intended to avoid duplication of benefits while at the same time preserving certain rights to coverage under all Plans under which the Insured Person is covered.

DEFINITIONS

The words shown below have special meanings when used in this provision. Please read these definitions carefully. Throughout this provision, these defined terms appear with their initial letter capitalized.

Allowable Expense: The charge for any health care service, supply or other item of expense for which the Insured Person is liable when the health care service, supply or other item of expense is covered at least in part under any of the Plans involved, except where a statute requires another definition, or as otherwise stated below. When this Policy is coordinating benefits with a Plan that provides benefits only for dental care, vision care, prescription drugs or hearing aids, Allowable Expense is limited to like items of expense. We will not consider the difference between the cost of a private Hospital room and that of a semi-private Hospital room as an Allowable Expense unless the stay in a private room is Medically Necessary and Appropriate.

When this Policy is coordinating benefits with a Plan that restricts coordination of benefits to a specific coverage, We will only consider corresponding services, supplies or items of expense to which coordination of benefits applies as an Allowable Expense.

Claim Determination Period: A Policy Year, or any portion of a Policy Year, during which an Insured Person is covered by this Policy and at least one other Plan and incurs one or more Allowable Expense(s) under such Plans.

Plan: Coverage with which coordination of benefits is allowed. Plan includes:

1. Group insurance and group subscriber contracts, including insurance continued pursuant to a Federal or State continuation law;
2. Self-funded arrangements of group or group-type coverage, including insurance continued pursuant to a Federal or State continuation law;
3. Group or group-type coverage through a health maintenance organization (HMO) or other prepayment, group practice and individual practice Plans, including insurance continued pursuant to a Federal or State continuation law;
4. Group Hospital indemnity benefit amounts that exceed $150.00 per day;
5. Medicare or other governmental benefits, except when, pursuant to law, the benefits must be treated as in excess of those of any private insurance Plan or non-governmental Plan.

Plan does not include:

1. Individual or family insurance contracts or subscriber contracts;
2. Individual or family coverage through a health maintenance organization or under any other prepayment, group practice and individual practice Plan s;
3. Group or group-type coverage where the cost of coverage is paid solely by the Insured Person except that coverage being continued pursuant to a Federal or State continuation law shall be considered a Plan;
4. Group Hospital indemnity benefit amounts of $150.00 per day or less;

5. School Accident-type coverage;
6. A State Plan under Medicaid.

Primary Plan: A Plan whose benefits for an Insured Person's health care coverage must be determined without taking into consideration the existence of any other Plan. There may be more than one Primary Plan. A Plan will be the Primary Plan if either "1." or "2." below exist:

1. The Plan has no order of benefit determination rules, or it has rules that differ from those contained in this Coordination of Benefits and Services provision; or
2. All Plans which cover the Insured Person use order of benefit determination rules consistent with those contained in the Coordination of Benefits and Services provision and under those rules, the Plan determines its benefits first.

Secondary Plan: A Plan which is not a Primary Plan. If An Insured Person is covered by more than one Secondary Plan, the order of benefit determination rules of this Coordination of Benefits and Services provision shall be used to determine the order in which the benefits payable under the multiple Secondary Plans are paid in relation to each other. The benefits of each Secondary Plan may take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plan which, under this COB provision, has its benefits determined before those of that Secondary Plan.

PRIMARY AND SECONDARY PLAN

We consider each Plan separately when coordinating payments. The Primary Plan pays or provides services or supplies first, without taking into consideration the existence of a Secondary Plan. If a Plan has no COB provision, or if the order of benefit determination rules differ from those set forth in these provisions, it is the Primary Plan.

A Secondary Plan takes into consideration the benefits provided by a Primary Plan when, according to the rules set forth below, the Plan is the Secondary Plan. If there is more than one Secondary Plan, the order of benefit determination rules determine the order among the Secondary Plans. During each claim determination period the Secondary Plan(s) will pay up to the remaining unpaid Allowable Expenses, but no Secondary Plan will pay more than it would have paid if it had been the Primary Plan. The method the Secondary Plan uses to determine the amount to pay is set forth below in the "Procedures to be Followed by the Secondary Plan to Calculate Benefits" section of this provision.

The Secondary Plan shall not reduce Allowable Expenses for medically necessary and appropriate services or supplies on the basis that precertification, preapproval, notification or second surgical opinion procedures were not followed.

RULES FOR THE ORDER OF BENEFIT DETERMINATION

The benefits of the Plan that covers the Insured Person as an employee, member, subscriber or retiree shall be determined before those of the Plan that covers the Insured Person as a Dependent. The coverage as an employee, member, subscriber or retiree is the Primary Plan.

The benefits of the Plan that covers the Insured Person as an employee who is neither laid off nor retired, or as a Dependent of such person, shall be determined before those for the Plan that covers the Insured Person as a laid off or retired employee, or as such a person's Dependent. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

The benefits of the Plan that covers the Insured Person as an employee, member, subscriber or retiree, or Dependent of such person, shall be determined before those of the Plan that covers the Insured Person under a right of continuation pursuant to Federal or State law. If the other Plan does not contain this rule, and as a result the Plans do not agree on the order of benefit determination, this portion of this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are neither separated nor divorced, the following rules apply:

1. The benefits of the Plan of the parent whose birthday falls earlier in the Calendar Year shall be determined before those of the parent whose birthday falls later in the Calendar Year.
2. If both parents have the same birthday, the benefits of the Plan which covered the parent for a longer period of time shall be determined before those of the Plan which covered the other parent for a shorter period of time.
3. "Birthday" as used above, refers only to month and day in a calendar year, not the year in which the parent was born.
4. If the other Plan contains a provision that determines the order of benefits based on the gender of the parent, the birthday rule in this provision shall be ignored.

If a child is covered as a Dependent under Plans through both parents, and the parents are separated or divorced, the following rules apply:

1. The benefits of the Plan of the parent with custody of the child shall be determined first.
2. The benefits of the Plan of the spouse of the parent with custody shall be determined second.
3. The benefits of the Plan of the parent without custody shall be determined last.
4. If the terms of a court decree state that one of the parents is responsible for the health care expenses for the child, and if the entity providing coverage under that Plan has actual knowledge of the terms of the court decree, then the benefits of that Plan shall be determined first. The benefits of the Plan of the other parent shall be considered as secondary. Until the entity providing coverage under the Plan has knowledge of the terms of the court decree regarding health care expenses, this portion of this provision shall be ignored.

If the above order of benefits does not establish which Plan is the Primary Plan, the benefits of the Plan that covers the employee, member or subscriber for a longer period of time shall be determined before the benefits of the Plan(s) that covered the person for a shorter period of time.

Procedures to be Followed by the Secondary Plan to Calculate Benefits: In order to determine which procedure to follow it is necessary to consider:

1. The basis on which the Primary Plan and the Secondary Plan pay benefits; and
2. Whether the provider who provides or arranges the services and supplies is in the network of either the Primary Plan or the Secondary Plan.

Benefits may be based on the; Usual and Reasonable charge, or some similar term. This means that the provider bills a charge and the Insured Person may be held liable for the full amount of the billed charge. In this section, a Plan that bases benefits on a Usual and Reasonable charge is called a "U & R Plan".

Benefits may be based on a contractual fee schedule, sometimes called a negotiated fee schedule, or some similar term. This means that although a provider, called a network provider, bills a charge, the Insured Person may be held liable only for an amount up to the negotiated fee. In this section, a Plan that bases benefits on a negotiated fee schedule is called a "Fee Schedule Plan".

If the Insured Person uses the services of a non-network provider, the Plan will be treated as a U & R Plan even though the Plan under which he or she is covered allows for a fee schedule.

Payment to the provider may be based on a "capitation". This means that the HMO or other Plan pays the provider a fixed amount per Insured Person. The Insured Person is liable only for the applicable Deductible, Coinsurance or Copayment. If the Insured Person uses the services of a non-network provider, the HMO or other Plan will only pay benefits in the event of emergency care or urgent care. In this section, a Plan that pays providers based upon capitation is called a "Capitation Plan".

In the rules below, "provider" refers to the provider who provides or arranges the services or supplies and "HMO " refers to a health maintenance organization Plan.

Primary Plan is U & R Plan and Secondary Plan is U & R Plan: The Secondary Plan shall pay the lesser of:

1. The difference between the amount of the billed charges and the amount paid by the Primary Plan; or
2. The amount the Secondary Plan would have paid if it had been the Primary Plan.

When the benefits of the Secondary Plan are reduced as a result of this calculation, each benefit shall be reduced in proportion, and the amount paid shall be charged against any applicable benefit limit of the Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is Fee Schedule Plan: If the provider is a network provider in both the Primary Plan and the Secondary Plan, the Allowable Expense shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

1. The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
2. The amount the Secondary Plan would have paid if it had been the Primary Plan.

The total amount the provider receives from the Primary Plan, the Secondary Plan and the Insured Person shall not exceed the fee schedule of the Primary Plan. In no event shall the Insured Person be responsible for any payment in excess of the Deductible, Coinsurance or Copayment of the Secondary Plan.

Primary Plan is U & R Plan and Secondary Plan is Fee Schedule Plan: If the provider is a network provider in the Secondary Plan, the Secondary Plan shall pay the lesser of:

1. The difference between the amount of the billed charges for the Allowable Expenses and the amount paid by the Primary Plan; or
2. The amount the Secondary Plan would have paid if it had been the Primary Plan.

The Insured Person shall only be liable for the Deductible, Coinsurance or Copayment under the Secondary Plan if the Insured Person has no liability for Deductible, Coinsurance or Copayment under the Primary Plan and the total payments by both the Primary and Secondary Plans are less than the provider's billed charges. In no event shall the Insured Person be responsible for any payment in excess of the Deductible, Coinsurance or Copayment of the Secondary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is U & R Plan: If the provider is a network provider in the Primary Plan, the Allowable Expense considered by the Secondary Plan shall be the fee schedule of the Primary Plan. The Secondary Plan shall pay the lesser of:

1. The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
2. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Fee Schedule Plan and Secondary Plan is U & R Plan or Fee Schedule Plan: If the Primary Plan is an HMO Plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured Person receives from a non-network provider is not considered as urgent care or emergency care, the Secondary Plan shall pay benefits as if it were the Primary Plan.

Primary Plan is Capitation Plan and Secondary Plan is Fee Schedule Plan or U & R Plan: If the Insured Person receives services or supplies from a provider who is in the network of both the Primary Plan and the Secondary Plan, the Secondary Plan shall pay the lesser of:

1. The amount of any Deductible, Coinsurance or Copayment required by the Primary Plan; or
2. The amount the Secondary Plan would have paid if it had been the Primary Plan.

Primary Plan is Capitation Plan or Fee Schedule Plan or U & R Plan and Secondary Plan is Capitation Plan: If the Insured Person receives services or supplies from a provider who is in the network of the Secondary Plan, the Secondary Plan shall be liable to pay the capitation to the provider and shall not be liable to pay the Deductible, Coinsurance or Copayment imposed by the Primary Plan. The Insured Person shall not be liable to pay any Deductible, Coinsurance or Copayments of either the Primary Plan or the Secondary Plan.

Primary Plan is an HMO and Secondary Plan is an HMO: If the Primary Plan is an HMO Plan that does not allow for the use of non-network providers except in the event of urgent care or emergency care and the service or supply the Insured Person receives from a non-network provider is not considered as urgent care or emergency care, but the provider is in the network of the Secondary Plan, the Secondary Plan shall pay benefits as if it were the Primary Plan, except that the Primary Plan shall pay out-of-Network services, if any, authorized by the Primary Plan.

Section 7 - Appeals Procedure

The Insured Person may not file an appeal on an Adverse Benefit Determination based on eligibility (including rescission), items listed in the Exclusions and Limitations section that are not related to Medical Necessity within 180 days of receipt of the Adverse Benefit Determination.

Adverse Benefit Determination means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.

Final Internal Adverse Benefit Determination means an Adverse Benefit Determination that has been upheld by Us at the completion of the internal appeal process, an Adverse Benefit Determination with respect to which We have waived Our right to an internal review of the appeal, an Adverse Benefit Determination for which We did not comply with the requirements of the New Jersey appeals requirements and an Adverse Benefit Determination for which the Insured Person or Physician or other provider has applied for expedited external review at the same time as applying for an expedited internal appeal.

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

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

Internal Review Procedure

1. In the event of an Adverse Benefit Determination, We will notify the Insured Person immediately in writing of Our decision and the reason for the Adverse Benefit Determination. The notice will include a description of any additional information that might be necessary for reconsideration of the claim and the notice will also describe the right to appeal. The Insured Person also had the right to contact the Commissioner of Banking and Insurance or his or her office at any time.

   New Jersey Department of Banking and Insurance
   20 West State Street
   PO Box 325
   Trenton, NJ 08625
   Phone: 609-292-7272
   Hotline: 800-446-7467

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 Benefit Determination. The Insured Person does not have the right to attend, or have an authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, may: a. review all documents related to the claim and submit written comments and issues related to the denial; and b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

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

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

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

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

   In the case of an Adverse Benefit 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 Benefit Determination. The clinical peer(s) shall not have been involved in the initial Adverse Benefit Determination. We shall ensure that the individuals reviewing the Adverse Benefit Determination have appropriate expertise.

   An Adverse Benefit Determination will be culturally and linguistically appropriate. It will include:

   1. Information identifying the claim involved, date of service, health care provider, and claim amount (if applicable). The notice will include a statement regarding the availability, on request, of the diagnosis code and its meaning and treatment code and its meaning. A request for

the diagnosis and treatment information will be responded to as soon as practicable. The request itself shall not be considered a request for an appeal.

2. The reason for the Adverse Benefit Determination, including denial code and its meaning, as well as a description of the standard We used in the denial; and
3. Information regarding the availability and contact information for the consumer assistance program at the Department of Banking and Insurance.

Expedited reviews of grievances involving an Adverse Benefit Determination

We shall provide expedited review of a grievance involving an Adverse Benefit Determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility. The Insured Person or the Insured Person's authorized representative , including a Physician acting on behalf of the Insured Person with the Insured Person's consent, 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 Benefit Determination. The clinical peer or peers shall not have been involved in making the initial Adverse Benefit Determination. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the Insured Person or, if applicable, the Insured Person's authorized representative , including a Physician acting on behalf of the Insured Person with the Insured Person's consent, and Us by telephone, facsimile or the most expeditious method available. An expedited review decision shall be made and the Insured Person or, if applicable, the Insured Person's authorized representative , including a Physician acting on behalf of the Insured Person with the Insured Person's consent, 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 Benefit Determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the Insured Person until the Insured Person has been notified of the determination.

If the Insured Person Disagrees with Our Internal Review Determination

In the event that the Insured Person disagrees with Our internal review determination, the Insured Person or his or her authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, may:

1. File a complaint with the Department of Banking and Insurance; or
2. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

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

External Review Procedure

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an Adverse Benefit Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

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

   An external review may be requested within 60 days after the Insured Person receives Our adverse benefit determination. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.
2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person, including a Physician acting on behalf of the Insured Person with the Insured Person's consent.
3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.
4. We will review the request and if it is:
   a. Complete we will initiate the external review and notify the Insured Person of:
      i. The name and contact information for the assigned independent review organization or the Commissioner of Banking and Insurance as applicable for the purpose of submitting additional information; and
      ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or Commissioner of Banking and Insurance to consider when conducting the external review. However, this doesn't apply to expedited request or external reviews that involve an experimental or investigational treatment.
   b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.
5. We will not afford the Insured Person an external review if:
   a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   b. The Insured Person has failed to exhaust Our internal review process; or
   c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

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

a. The reason for the denial; and
b. That the denial may be appealed to the Commissioner of Insurance.

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

External Review of Denial of Experimental or Investigative Treatment: Within sixty (60) days after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or the Insured Person's authorized representative , including a Physician acting on behalf of the Insured Person with the Insured Person's consent, may file a request for external review with the Commissioner of Banking and Insurance.

An Insured Person or the Insured Person's provider, acting on behalf of the Insured Person with the Insured Person's consent, may make an oral request for an external review of the Adverse Benefit Determination or Final Internal Adverse Benefit Determination if the Insured Person's treating Physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

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

Service Representative:

UNIVERSITY HEALTH PLANS, INC.
A Risk Strategies Company
15 Pacella Park Drive, Randolph, MA 02368
(800) 437-6448 • www.universityhealthplans.com

Underwritten by:

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

as policy form # NBH-280 (2018) NJ

Administered by:

CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue, Springfield, MA 01104
(413) 452-5370 or Toll Free (877) 657-5030 • www.chpstudenthealth.com

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

go to www.consolidatedhealthplan.com/about/hipaa

or ***Request one from the Health office at your school***

or ***Request one from:***

UNIVERSITY HEALTH PLANS, INC.
A Risk Strategies Company
15 Pacella Park Drive, Randolph, MA 02368
(800) 437-6448
www.universityhealthplans.com

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

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

Representations of this plan must be approved by Us.

IMPORTANT

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

PRESCRIPTION DRUG RIDER

The Policy and Certificate to which this Rider is attached is amended as described. This Rider is effective on the issue date of the Policy.

The Prescription Drug Benefit description shown in the Schedule of Benefits is deleted in its entirety. It is replaced with the Prescription Drug benefit description below.

Prescription Drugs Retail Pharmacy Cost sharing does not apply to Affordable Care Act (ACA) Preventive Care prescriptions are filled at a participating network pharmacy.		
DESCRIPTION	**NETWORK**	**NON-NETWORK COST SHARING DESCRIPTION**
Retail		
TIER 1 Generic Non-Network benefits are provided on a reimbursement basis.	100% of PPO Allowance for Covered Medical Expenses after copayment Copayment: $15	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: $15
TIER 2 Preferred Brand Drug Non-Network benefits are provided on a reimbursement basis.	100% of PPO Allowance for Covered Medical Expenses after copayment Copayment: $30	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: $30
TIER 3 Brand-Name Drug Non-Network benefits are provided on a reimbursement basis.	100% of PPO Allowance for Covered Medical Expenses after copayment Copayment: $50	100% of Usual and Reasonable Charge for Covered Medical Expenses after copayment Copayment: $50

The **Definitions** section of the Policy is amended by deleting definitions of Brand Name Drug, Formulary, and Generic Drug.

The **Definitions** Section of the Policy is amended by adding the definitions below.
Brand-Name Drug means a Prescription Drug which protected by a patent and is sold by a drug company under a specific name or trademark. The tier status is shown in the Formulary.

Formulary means a list of medications covered by the Policy. Use of medications listed the Formulary is intended to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary lists the type of drug and tier status.

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

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

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

The Prescription Drugs benefit is deleted in its entirety from the **Description of Benefits** section of the Policy. It is replaced with the benefit described below.

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

1. **Off-Label Drug Treatments** benefits are available if all of the conditions listed below are met. It is the responsibility of the prescribing Physician to submit documentation to Us that supports compliance with these conditions.
   a. The drug is approved by the FDA;
   b. The drug is prescribed for the Treatment of a Life-Threatening condition, including cancer, HIV or AIDS;
   c. 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 Dis-

pensing Information, volume 1, "Drug Information for Health Care Professionals"; or d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

As used in this benefit, Life-Threatening means:
1) A disease or condition where the likelihood of death is high unless the course of the disease is interrupted; or
2) Disease or condition which may be fatal and where the end point of clinical intervention is survival.

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

3. **Tobacco cessation prescription and over-the-counter (OTC) drugs** benefits are payable for tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.chpstudenthealth.com or call 1-877-657-5030.

LIMITATIONS AND EXCLUSIONS
The Limitations and Exclusions described below apply only to this Prescription Drug Rider.

LIMITATIONS
1. **Step Therapy** when medications for the Treatment of any Covered Injury or Covered Sickness are restricted for use by a step therapy or fail-first protocol, the prescribing Physician may request an override of the restriction from Us. An override of that restriction will be granted by Us when the Physician provides all necessary information to perform the override review. The information required is listed below.
   a. The prescribing Physician can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of the Insured Person's Covered Injury or Covered Sickness; or
   b. Based on sound clinical evidence or medical and scientific evidence:
      1) The prescribing Physician can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured Person and known characteristics of the drug regimen; or
      2) The prescribing Physician can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the Insured Person.

2. **Specialty Prescription Drugs** may be limited access or distribution and are limited to no more than a 30-day supply/subject to supply limits.

As used in this benefit, Specialty Prescription Drugs are Prescription Drugs which:
a. Are only approved to treat limited patient populations, indications, or conditions;
b. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
c. 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.

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

4. **Tier Status** – The tier status of a Prescription Drug may change. Such changes may occur without prior notice to the Insured Person. However, if the Insured Person has a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug) We will notify the Insured Person of the change. When such changes occur, the out-of-pocket expense may change. The most current tier status is available at www.chpstudenthealth.com or by calling 1-877-657-5030 the number on the Insured Person's ID card.

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

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

Expedited Review of a Formulary Exception – If the Insured Person is suffering from a health condition that may seriously jeopardize his or her health, life, ability to regain maximum function, or if the Insured Person is undergoing a current course of

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

6. **Supply Limits** – We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. The Insured Person is responsible for one (1) cost sharing amount for up to a 30-day supply.

EXCLUSIONS

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

- A drug which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written;
- a drug which has an over-the-counter equivalent;
- Brand-Name Prescription Drugs with generic equivalents;
- allergy sera and extracts administered via injection;
- weight control drugs;
- fertility drugs;
- vitamins, minerals, food supplements;
- sexual enhancements drugs;
- dietary supplements;
- cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or Treatment of acne except as specifically provided in this Rider;
- 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 the Insured Person's coverage terminates;
- a drug that is consumed or administered at the place where it is dispensed;
- any drug that the FDA determines is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- bulk chemicals;
- non-insulin syringes surgical supplies durable medical equipment/medical devices with the exception of diabetic blood monitors and kits;
- stimulants;
- repackaged products;
- blood components;
- single agent opioids;
- immunology products.

All other provisions of the Policy to which this Rider is attached remain the same.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

President

Claim Procedures

In the event of an Injury or Sickness the Insured Student should:

1. If at Drew University, report immediately to Health Services or Counseling and Psychological Services for proper treatment; or
2. If away from University or if Health Services or Counseling and Psychological Services is closed, consult a Physician and follow his/her advice.
3. A claim form is not required to submit a claim. However, an itemized medical bill, HCFA 1500, or UB92 form should be used to submit expenses. The Insured Student/Person's name and identification number need to be included.
4. The form(s) should be mailed **within ninety (90) days** from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. Retain a copy for your records and mail claims to **Cigna, PO Box 188061, Chattanooga, TN 37422-8061.**
5. If your treatment is a result of an accident you will receive an accident form from Consolidated Health Plans, Inc. and be asked to provide additional information in order to process the claim. If there is question as to whether another insurance plan may be applicable to any treatment received, you may also receive written notification from Consolidated Health Plans, Inc. and be asked to provide information on any other insurance plan in which you are enrolled. You must respond to this correspondence before the claim can be processed.
6. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Consolidated Health Plans, Inc. at www.chpstudenthealth.com or call (800) 633-7867. Any provision of this Plan, which on the effective date, is in conflict with the statues of the state in which the Plan is issued will be administered to conform to the requirements of the state statutes.

VALUE ADDED SERVICES

The following services are not part of the Indemnity Plan Underwritten by National Guardian Life Insurance Company. These value added options are provided by Consolidated Health Plans.

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.chpstudenthealth.com

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-877-657-5030. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 *or* if you are in a foreign country, call collect at: 715.295.9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

CareConnect
Integrated Behavioral Health from CHP Student Health

With CareConnect from CHP Student Health, students have 24/7 access to professional assistance to help manage personal concerns, emotional issues, transition and adjustment concerns, academic stress, career development, and the demands of daily and family obligations.

Members in need of assistance simply call the behavioral health hotline on their ID card, 888-857-5462, or via the CHP Student Health mobile app for immediate access to a masters-level mental health professional. Students are run through a clinical assessment to determine if CareConnect counseling, health center referral, or other treatment is necessary. To access mobile features, students simply download their school's app in their device's app store.