Filing at a Glance

Company:	National Union Fire Insurance Company of Pittsburgh, Pa.
Product Name:	Educational Markets
State:	District of Columbia
TOI:	H04 Health - Blanket Accident /Sickness
Sub-TOI:	H04.001 Student
Filing Type:	Rate
Date Submitted:	08/02/2013
SERFF Tr Num:	AGDE-129138343
SERFF Status:	Pending State Action
State Tr Num:	
State Status:	
Co Tr Num:	NUFIC13CAS01 - RATE
Implementation Date Requested:	On Approval
Author(s):	Penny Berry, Veronica Bullock, Bernard Ganley
Reviewer(s):	Darniece Shirley (primary), Alula Selassie, Donghan Xu
Disposition Date:	
Disposition Status:	
Implementation Date:	

State Filing Description:

State: *District of Columbia* **Filing Company:** *National Union Fire Insurance Company of Pittsburgh, Pa.*

TOI/Sub-TOI: *H04 Health - Blanket Accident /Sickness/H04.001 Student*
Product Name: *Educational Markets*
Project Name/Number: *Howard University Single Case filing/NUFIC13CAS01*

General Information

Project Name: Howard University Single Case filing
Project Number: NUFIC13CAS01
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Group Market Type: Blanket
Filing Status Changed: 08/26/2013
State Status Changed:
Created By: Penny Berry
Corresponding Filing Tracking Number:

Status of Filing in Domicile:
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Overall Rate Impact:

Deemer Date:
Submitted By: Penny Berry

PPACA: Non-Grandfathered Immed Mkt Reforms

PPACA Notes: null

Include Exchange Intentions: No

Filing Description:

RE: National Union Fire Insurance Company of Pittsburgh, Pa.
NAIC # 012-19445, FEIN 25-0687550

Rate Filing for Student Blanket Accident and Sickness Insurance Program
S30749NUFIC-DC-HU Student Blanket Accident and Sickness Policy
S30753NUFIC-DC-HU Application for Student Accident and Sickness Insurance Policy
Actuarial Memorandum and Rate Manual

We are submitting rates applicable to the above referenced forms for your review and approval. The forms are new and are not intended to replace any previously filed forms. These forms will be used for issue to Howard University and are intended to provide accident and sickness insurance coverage to eligible students of that learning institution. The forms will be used for issue to Howard University for the 2013-2014 school year. We respectfully request that the actuarial memorandum and rate information be kept confidential where not prohibited by law.

The forms filing can be found under SERFF tracking number AGDE-129138344.

We appreciate your review and look forward to your approval of these forms. Please don’t hesitate to contact me if you have any questions concerning this submission.

Respectfully submitted,

Company and Contact

Filing Contact Information

Penny Berry, Product Analyst
503 Carr Road
3rd Floor
Wilmington, DE 19809

penny.berry@chartisinsurance.com
888-396-5369 [Phone] 31721 [Ext]
302-830-4466 [FAX]

State: *District of Columbia* ***Filing Company:*** *National Union Fire Insurance Company of Pittsburgh, Pa.*

TOI/Sub-TOI: *H04 Health - Blanket Accident /Sickness/H04.001 Student*

Product Name: *Educational Markets*

Project Name/Number: *Howard University Single Case filing/NUFIC13CAS01*

Filing Company Information

National Union Fire Insurance Company of Pittsburgh, Pa.
503 Carr Road
3rd Floor
Wilmington, DE 19809
(888) 396-5369 ext. 31722[Phone]

CoCode: 19445
Group Code: 12
Group Name: AIG
FEIN Number: 25-0687550

State of Domicile: Pennsylvania
Company Type:
State ID Number:

Filing Fees

Fee Required? No

Retaliatory? No

Fee Explanation:

SERFF Tracking #:	*AGDE-129138343*	***State Tracking #:***		***Company Tracking #:***	*NUFIC13CAS01 - RATE*

State:	*District of Columbia*	***Filing Company:***	*National Union Fire Insurance Company of Pittsburgh, Pa.*
TOI/Sub-TOI:	*H04 Health - Blanket Accident /Sickness/H04.001 Student*		
Product Name:	*Educational Markets*		
Project Name/Number:	*Howard University Single Case filing/NUFIC13CAS01*		

Correspondence Summary

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Darniece Shirley	08/14/2013	08/14/2013

Response Letters

Responded By	Created On	Date Submitted
Penny Berry	08/16/2013	08/26/2013

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.

TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student

Product Name: Educational Markets

Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/14/2013
Submitted Date	08/14/2013
Respond By Date	09/04/2013

Dear Penny Berry,

Introduction:

Thank you for your recent filing. Please see below for additional information requested to continue review of the rate filing.

Objection 1

Comments: Please explain why the filing has yet to be filed in Pennsylvania, the State of Domiciliary.

Objection 2

Comments: The Rate Review Data Detail section of the filing is missing. The State understands this is not required for this type of filing; however completing it would be preferred. Please correct, via post-submission update.

Objection 3

- Actuarial Memorandum (Supporting Document)

- Actuarial Justification (Supporting Document)

- Actuarial Memorandum and Certifications (Supporting Document)

- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)

- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)

- Rate Manual, [S30749NUFIC-DC-HU] (Rate)

Comments: Please provide the currently approved rate filing SERFF Tracking#. Was this the initial filing for this product?

Objection 4

- Actuarial Memorandum (Supporting Document)

- Actuarial Justification (Supporting Document)

- Actuarial Memorandum and Certifications (Supporting Document)

- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)

- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)

Comments: Schedule of Benefits: Plan A refers to except when a student graduates from the University and that student is no longer eligible for services at the SHC. Please explain when coverage ceases for a student who has graduated from the University.

Objection 5

- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)

- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)

Comments: S30494NUFIC-NM-UNM Cover Page, Section 1 (Schedule of Benefits) specifically refers to the University of New Mexico. In addition, the noted form is distinctly referencing the University of New Mexico in its form number. Please confirm this filing is for Howard University and all associated forms will reference Howard University. Please note the Departments Forms reviewer is aware of this and may note it in respective forms objections. Any necessary changes should be submitted to the Department for review.

Objection 6

- Cover Letter All Filings (Supporting Document)

- Certificate of Authority to File (Supporting Document)

- Actuarial Memorandum (Supporting Document)

- Actuarial Justification (Supporting Document)

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.

TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student

Product Name: Educational Markets

Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

- District of Columbia and Countrywide Loss Ratio Analysis (P&C) (Supporting Document)
- District of Columbia and Countrywide Experience for the Last 5 Years (P&C) (Supporting Document)
- Consumer Disclosure Form (Supporting Document)
- Actuarial Memorandum and Certifications (Supporting Document)
- Unified Rate Review Template (Supporting Document)
- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)
- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)
- Rate Manual, [S30749NUFIC-DC-HU] (Rate)

Comments: Please note, for policy years beginning on or after January 1, 2014, a health insurance issuer offering student health insurance coverage must comply with the annual dollar limits requirements in §147.126.

Objection 7

- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)
- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)

Comments: If a student changes from Plan A to Plan B, for example at an allowable time per the policy terms/conditions, does that students coverage still terminate at the original Plans date?

Objection 8

- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)
- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)
- Rate Manual, [S30749NUFIC-DC-HU] (Rate)

Comments: Per 45 CFR Part 144.103 student health insurance coverage must be less than 12 months in duration, including any potential extensions. Please explain how it is possible under Section 1 Schedule of Benefits, Specific Effective and Termination Dates, bullet #5 that this qualifies as short-term limited duration coverage. Per this bullet point, this rate filing would constitute individual health insurance coverage subject to the individual market requirements of the PHS Act and the Affordable Care Act. Please address, explain and respond accordingly.

Objection 9

- Cover Letter All Filings (Supporting Document)
- Certificate of Authority to File (Supporting Document)
- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- District of Columbia and Countrywide Loss Ratio Analysis (P&C) (Supporting Document)
- District of Columbia and Countrywide Experience for the Last 5 Years (P&C) (Supporting Document)
- Consumer Disclosure Form (Supporting Document)
- Actuarial Memorandum and Certifications (Supporting Document)
- Unified Rate Review Template (Supporting Document)
- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)
- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)
- Rate Manual, [S30749NUFIC-DC-HU] (Rate)

Comments: Please confirm: This rate review is limited to DC resident policyholders or DC domiciled group certificate holders. All other rate requests will need to be reviewed by that respective state.

Objection 10

- Cover Letter All Filings (Supporting Document)
- Certificate of Authority to File (Supporting Document)

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.

TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student

Product Name: Educational Markets

Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

- Actuarial Memorandum (Supporting Document)
- Actuarial Justification (Supporting Document)
- District of Columbia and Countrywide Loss Ratio Analysis (P&C) (Supporting Document)
- District of Columbia and Countrywide Experience for the Last 5 Years (P&C) (Supporting Document)
- Consumer Disclosure Form (Supporting Document)
- Actuarial Memorandum and Certifications (Supporting Document)
- Unified Rate Review Template (Supporting Document)
- Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)
- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)
- Rate Manual, [S30749NUFIC-DC-HU] (Rate)

Comments: Please note, this rate filing is subject to conformity with the corresponding forms filing. This department reserves the right to withdraw the filing if not.

Conclusion:

Sincerely,
Darniece Shirley

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/16/2013
Submitted Date	08/26/2013

Dear Darniece Shirley,

Introduction:

Thank you for your letter and for speaking with me over the phone on August 16, 2013.

Response 1

Comments:

In regards to your comment 1, this filing has not been filed in our domicile state of Pennsylvania as these forms are deregulated and therefore no filing is required.

Related Objection 1

Comments: Please explain why the filing has yet to be filed in Pennsylvania, the State of Domiciliary.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments:

In regards to your comment 2, I have revised the Rate Review Data Detail section of this filing so all fields are complete. Those changes will appear in the post submission update submitted on August 26, 2013.

Related Objection 2

Comments: The Rate Review Data Detail section of the filing is missing. The State understands this is not required for this type of filing; however completing it would be preferred. Please correct, via post-submission update.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

No Rate/Rule Schedule items changed.

Response 3

Comments:

In response to your comment 3, this is an initial filing and there is no previous SERFF Tracking number. Our past research on rate filing requirements for blanket insurance was flawed. It indicated that actuarial materials were not required to be filed in the District. This error was discovered only recently and therefore the rates are now being submitted.

Related Objection 3

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*
- *Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)*
- *Rate Manual, [S30749NUFIC-DC-HU] (Rate)*
- *Actuarial Memorandum (Supporting Document)*
- *Actuarial Justification (Supporting Document)*
- *Actuarial Memorandum and Certifications (Supporting Document)*

Comments: Please provide the currently approved rate filing SERFF Tracking#. Was this the initial filing for this product?

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Response 4

Comments:

In regards to comment 4, I inadvertently attached the wrong forms when this was submitted. I have reattached the correct forms and your concern regarding "...except when a student graduates from the University and that student is no longer eligible for services at the SHC" is not in the policy S30749NUFIC-DC-HU. I apologize for any inconvenience this may have caused.

Related Objection 4

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*
- *Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)*

- *Actuarial Memorandum (Supporting Document)*
- *Actuarial Justification (Supporting Document)*
- *Actuarial Memorandum and Certifications (Supporting Document)*

Comments: Schedule of Benefits: Plan A refers to except when a student graduates from the University and that student is no longer eligible for services at the SHC. Please explain when coverage ceases for a student who has graduated from the University.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Response 5

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

Comments:

In regards to comment 5, I inadvertently attached the wrong forms when this was submitted. I have reattached the correct forms and your concern regarding this filing all forms will reference Howard University. I apologize for any inconvenience this may have caused.

Related Objection 5

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*
- *Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)*

Comments: S30494NUFIC-NM-UNM Cover Page, Section 1 (Schedule of Benefits) specifically refers to the University of New Mexico. In addition, the noted form is distinctly referencing the University of New Mexico in its form number. Please confirm this filing is for Howard University and all associated forms will reference Howard University. Please note the Departments Forms reviewer is aware of this and may note it in respective forms objections. Any necessary changes should be submitted to the Department for review.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: AGDE-129138343 **State Tracking #:** **Company Tracking #:** NUFIC13CAS01 - RATE

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student
Product Name: Educational Markets
Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Response 6

Comments:

In regards to comment 6, I inadvertently attached the wrong forms when this was submitted. I have reattached the correct forms and your concern regarding the annual dollar limits requirements in 147.126 should be addressed in these forms. I apologize for any inconvenience this may have caused.

Related Objection 6

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*
- *Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)*
- *Rate Manual, [S30749NUFIC-DC-HU] (Rate)*

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

- *Cover Letter All Filings (Supporting Document)*
- *Certificate of Authority to File (Supporting Document)*
- *Actuarial Memorandum (Supporting Document)*
- *Actuarial Justification (Supporting Document)*
- *District of Columbia and Countrywide Loss Ratio Analysis (P&C) (Supporting Document)*
- *District of Columbia and Countrywide Experience for the Last 5 Years (P&C) (Supporting Document)*
- *Consumer Disclosure Form (Supporting Document)*
- *Actuarial Memorandum and Certifications (Supporting Document)*
- *Unified Rate Review Template (Supporting Document)*

Comments: Please note, for policy years beginning on or after January 1, 2014, a health insurance issuer offering student health insurance coverage must comply with the annual dollar limits requirements in §147.126.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: AGDE-129138343 **State Tracking #:** **Company Tracking #:** NUFIC13CAS01 - RATE

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student
Product Name: Educational Markets
Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Response 7

Comments:

In regards to comment 7, I inadvertently attached the wrong forms when this was submitted. I have reattached the correct forms and your concern regarding if a student changes from Plan A to Plan B does that student's coverage still terminate at the original Plan's date is an eligible student can only upgrade to Plan B at initial enrollment in the plan each policy year. DC Howared University plan coverage for an enrolled student will terminate at the end of the period for which premium has been paid or on the policy termination date, whichever occurs first. I apologize for any inconvenience this may have caused.

Related Objection 7

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*

- Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)

Comments: If a student changes from Plan A to Plan B, for example at an allowable time per the policy terms/conditions, does that students coverage still terminate at the original Plans date?

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Response 8

Comments:

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

In regards to comment 8, I inadvertently attached the wrong forms when this was submitted. I have reattached the correct forms and your concern regarding the bullet #5 in the Schedule of Benefits Specific Effective and Termination Dates is not part of the DC Howard University. I apologize for any inconvenience this may have caused.

Related Objection 8

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*
- *Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)*
- *Rate Manual, [S30749NUFIC-DC-HU] (Rate)*
- *Actuarial Memorandum (Supporting Document)*
- *Actuarial Justification (Supporting Document)*

Comments: Per 45 CFR Part 144.103 student health insurance coverage must be less than 12 months in duration, including any potential extensions. Please explain how it is possible under Section 1 Schedule of Benefits, Specific Effective and Termination Dates, bullet #5 that this qualifies as short-term limited duration coverage. Per this bullet point, this rate filing would constitute individual health insurance coverage subject to the individual market requirements of the PHS Act and the Affordable Care Act. Please address, explain and respond accordingly.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: AGDE-129138343 **State Tracking #:** **Company Tracking #:** NUFIC13CAS01 - RATE

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student
Product Name: Educational Markets
Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Response 9

Comments:

In regards to comment 9, I inadvertently attached the wrong forms when this was submitted. I have reattached the correct forms and your concern regarding that we confirm that the rate review is limited to DC resident policyholder or DC domiciled group certificate holders is confirmed. This policy will be issued to DC Howard University only. I apologize for any inconvenience this may have caused.

Related Objection 9

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*
- *Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)*

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

- *Rate Manual, [S30749NUFIC-DC-HU] (Rate)*
- *Cover Letter All Filings (Supporting Document)*
- *Certificate of Authority to File (Supporting Document)*
- *Actuarial Memorandum (Supporting Document)*
- *Actuarial Justification (Supporting Document)*
- *District of Columbia and Countrywide Loss Ratio Analysis (P&C) (Supporting Document)*
- *District of Columbia and Countrywide Experience for the Last 5 Years (P&C) (Supporting Document)*
- *Consumer Disclosure Form (Supporting Document)*
- *Actuarial Memorandum and Certifications (Supporting Document)*
- *Unified Rate Review Template (Supporting Document)*

Comments: Please confirm: This rate review is limited to DC resident policyholders or DC domiciled group certificate holders. All other rate requests will need to be reviewed by that respective state.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: AGDE-129138343 **State Tracking #:** **Company Tracking #:** NUFIC13CAS01 - RATE

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student
Product Name: Educational Markets
Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Response 10

Comments:

In regards to comment 10, I inadvertently attached the wrong forms when this was submitted. I have reattached the correct forms and your concern regarding the rates and forms not matching should be corrected. I apologize for any inconvenience this may have caused.

Related Objection 10

Applies To:

- *Student Blanket Accident and Sickness Policy, S30494NUFIC-NM-UNM (Form)*
- *Application for Student Accident and Sickness Insurance Policy, S30501NUFIC-NM-UNM (Form)*
- *Rate Manual, [S30749NUFIC-DC-HU] (Rate)*

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

- *Cover Letter All Filings (Supporting Document)*
- *Certificate of Authority to File (Supporting Document)*
- *Actuarial Memorandum (Supporting Document)*
- *Actuarial Justification (Supporting Document)*
- *District of Columbia and Countrywide Loss Ratio Analysis (P&C) (Supporting Document)*
- *District of Columbia and Countrywide Experience for the Last 5 Years (P&C) (Supporting Document)*
- *Consumer Disclosure Form (Supporting Document)*
- *Actuarial Memorandum and Certifications (Supporting Document)*
- *Unified Rate Review Template (Supporting Document)*

Comments: Please note, this rate filing is subject to conformity with the corresponding forms filing. This department reserves the right to withdraw the filing if not.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #: AGDE-129138343 **State Tracking #:** **Company Tracking #:** NUFIC13CAS01 - RATE

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student
Product Name: Educational Markets
Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
1	*Student Blanket Accident and Sickness Policy*	*S30494NUFIC-NM-UNM*	*POL*	*Initial*		*50.100*	*S30494NUFIC-NM-UNM .pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*
2	Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf	Date Submitted: 08/26/2013 By: Penny Berry
Previous Version								
2	*Application for Student Accident and Sickness Insurance Policy*	*S30501NUFIC-NM-UNM*	*AEF*	*Initial*		*54.000*	*S30501NUFIC-NM.pdf*	*Date Submitted: 08/02/2013 By: Penny Berry*

No Rate/Rule Schedule items changed.

Conclusion:

We appreciate your review and look forward to your approval of these forms. Please don't hesitate to contact me if you have any questions concerning this submission.

Sincerely,

Penny L. Berry
Filing Analyst,
A&H State Filings Division
Phone: (888) 396-5369 x 31721
Fax: (302) 830-4466
penny.berry@aig.com

SERFF Tracking #:	AGDE-129138343	**State Tracking #:**		**Company Tracking #:**	NUFIC13CAS01 - RATE

State:	District of Columbia	**Filing Company:**	National Union Fire Insurance Company of Pittsburgh, Pa.
TOI/Sub-TOI:	H04 Health - Blanket Accident /Sickness/H04.001 Student		
Product Name:	Educational Markets		
Project Name/Number:	Howard University Single Case filing/NUFIC13CAS01		

Sincerely,
Penny Berry

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.

TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student

Product Name: Educational Markets

Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Post Submission Update Request Submitted On 08/26/2013

Status:	Submitted
Created By:	Penny Berry

State: District of Columbia **Filing Company:** National Union Fire Insurance Company of Pittsburgh, Pa.

TOI/Sub-TOI: H04 Health - Blanket Accident /Sickness/H04.001 Student
Product Name: Educational Markets
Project Name/Number: Howard University Single Case filing/NUFIC13CAS01

Company Rate Information:

Company Name:National Union Fire Insurance Company of Pittsburgh, Pa.

Field Name	Requested Change	Prior Value
Overall % Indicated Change	0.000%	
Overall % Rate Impact	0.000%	
Written Premium Change for this Program	$0	
# of Policy Holders Affected for this Program	0	
Written Premium for this Program	$0	
Maximum %Change (where required)	0.000%	
Minimum %Change (where required)	0.000%	
FORMS:		
Affected Forms for Closed Blocks:	0	
Other Affected forms:	0	
REQUESTED RATE CHANGE INFORMATION:		
Min:	0.000	
Max:	0.000	
Weighted Avg.:	0.000	
PRIOR RATE:		
Total Earned Premium::	0.000	
Total Incurred Claims:	0.000	
Min:	0.000	
Max:	0.000	
Weighted Avg.:	0.000	
HMO - Covered Lives	0	
HMO - Policy Holders	0	
PPO - Covered Lives	0	
PPO - Policy Holders	0	
EPO - Covered Lives	0	
EPO - Policy Holders	0	
POS - Covered Lives	0	
POS - Policy Holders	0	
HSA - Covered Lives	0	
HSA - Policy Holders	0	
HDHP - Covered Lives	0	
HDHP - Policy Holders	0	
FFS - Covered Lives	0	
FFS - Policy Holders	0	
Other - Covered Lives	0	
Other - Policy Holders	0	

SERFF Tracking #:	*AGDE-129138343*	***State Tracking #:***		***Company Tracking #:***	*NUFIC13CAS01 - RATE*

State:	*District of Columbia*	***Filing Company:***	*National Union Fire Insurance Company of Pittsburgh, Pa.*
TOI/Sub-TOI:	*H04 Health - Blanket Accident /Sickness/H04.001 Student*		
Product Name:	*Educational Markets*		
Project Name/Number:	*Howard University Single Case filing/NUFIC13CAS01*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Student Blanket Accident and Sickness Policy	S30749NUFIC-DC-HU	POLA	Initial		55.200	S30749NUFIC-DC-HU.pdf
2		Application for Student Accident and Sickness Insurance Policy	S30753NUFIC-DC-HU	AEF	Initial		53.700	S30753NUFIC-DC-HU.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: Howard University

Policy Number: CAS9495454
Reference Number: CHH0091424

STUDENT BLANKET ACCIDENT AND SICKNESS POLICY

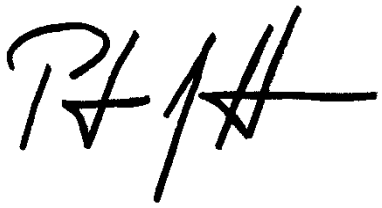
This Policy is a legal contract between this Policyholder and the Company. The Company agrees to insure eligible persons of the Policyholder against loss covered by this Policy subject to its provisions, limitations and exclusions. This Policy provides accident and sickness insurance to Covered Persons. The persons eligible to be Covered Persons are all persons described in the Description of Class section of the Schedule of Benefits.

This Policy is issued in consideration of payment of the required premium when due and the statements set forth in the signed Application For Student Blanket Accident and Sickness Insurance Policy which is attached to and made part of this Policy.

This Policy begins on this Policy Effective Date shown in the Schedule of Benefits and continues in effect until this Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid.

This Policy is governed by the laws of the state in which it is delivered.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Policy:



President

Secretary

NON-RENEWABLE ONE-YEAR TERM INSURANCE

PLEASE READ THIS POLICY CAREFULLY

Non-Participating Policy

TABLE OF CONTENTS

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

Policyholder Effective Date: **August 1, 2013**
Policyholder Termination Date: **July 31, 2014**

CLASS	DESCRIPTION OF CLASS
1	All full-time and part-time domestic students and international students at Howard University.

Subject to the terms of this Policy, Benefits will be provided only for the coverages indicated below; and only up to the amounts shown.

A Preferred Provider Organization (PPO) is an organization in which a group of Hospitals and Doctors have agreed to provide medical care services to Covered Persons. The PPO for this Policy will be selected by the Company. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to policy provisions. A Covered Person has the option to use a PPO provider or a non-PPO provider. Benefits applicable to both types of providers are shown below.

For treatment or care received at a Non-PPO provider, benefits for Eligible Expense will be payable at the Non-PPO level.

If treatment or care is received in a Non- PPO facility because of an Emergency Medical Condition, benefits for Eligible Expense are payable at the PPO level.

Emergency Services treatment or care rendered by a Non-PPO provider is mandated by the Patient Protection and Affordable Care Act to be provided at the same benefit and cost sharing level as services provided by PPO provider.

Benefits payable under this Policy for covered services rendered through the Preferred Provider Organization (PPO) network shall be based on the Allowable Charges of its providers.

Benefits payable under this Policy for covered services rendered outside the Preferred Provider Organization (Non-PPO) network shall be based on the Reasonable and Customary charges of the providers.

COVERAGE	BENEFIT AMOUNT
ACCIDENTAL DEATH AND DISMEMBERMENT - PLANS A & B:	
Maximum Benefit	$10,000

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT

ACCIDENT AND SICKNESS EXPENSE BENEFIT PLAN A:

BASIC ACCIDENT AND SICKNESS BENEFITS:

Basic Aggregate Maximum Benefit per Injury or Sickness per Policy Year $500,000

Deductible Amount:

Per Covered Person:	
PPO	$200
Non-PPO	$400

A referral from the Student Health Center is required before benefits are payable. This provision does not apply if: (a) the Student Health Center is closed, however, the Student must return to the Student Health Center for referral or necessary follow-up care; (b) covered service is rendered at another facility during school breaks or vacation times; (c) medical care is received when Student is more than 35 miles from campus; (d) medical care is obtained by a Student who is not eligible to use the Student Health Center; (e) for maternity; (f) dental treatment obtained in the Howard University Outpatient Clinic at the College of Dentistry; (g) for Mental Disorders; or (h) Emergency Medical Condition; however, the Student must return to the Student Health Center for necessary follow-up care. Benefits for Eligible Expenses incurred for medical care or treatment rendered for which no referral is obtained will be excluded from coverage. Benefits for Emergency Medical Condition will be payable at the PPO level whether treatment is received from a PPO provider or Non-PPO provider.

This referral requirement does not apply to the Covered Student's Dependent(s). Per Patient Protection and Affordable Care Act, if designation of a primary care physician is required, the Covered Person must be allowed to designate a physician who specializes in pediatrics as the child's primary care physician if the provider is in the network. No authorization or referral requirement shall apply to obstetrical or gynecological care provided by in-network providers.

	PPO	**Non-PPO**
NEEDLESTICK AND SPLATTER EXPENSE		
Covered Percentage	100%	80%
HOSPITAL EXPENSE:		
Daily Room and Board Maximum:	Average Semi-private Rate	
Covered Percentage Room and Board	100%	80%
Covered Percentage Hospital Miscellaneous	100%	80%
Intensive Care Unit	Included in the Daily Room and Board Maximum	
Pre-Admission Testing* (Hospital Confinement must occur within 3 days of the testing)		
Covered Percentage	100%	80%

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO
ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN A (continued):		
BASIC ACCIDENT AND SICKNESS BENEFITS (continued):		
HOSPITAL EXPENSE (continued): Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is: (a) rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service.		
Injury Covered Percentage	100%	80%
Sickness Covered Percentage	N/A	N/A
Physiotherapy during Hospital Confinement Covered Percentage	100%	80%
SURGICAL EXPENSE (Inpatient or Outpatient): Covered Percentage	100%	80%
Assistant Surgeon (Inpatient or Outpatient) Injury Covered Percentage	100%	80%
Sickness Covered Percentage	N/A	N/A
Anesthesia (Inpatient Only) Covered Percentage	100%	80%
Anesthesia (Outpatient Only) Injury Covered Percentage	100%	80%
Sickness Covered Percentage	25% of amount payable for Surgery	
IN-HOSPITAL DOCTOR'S FEES EXPENSE* Covered Percentage	100%	80%

*Limited to one visit per day.

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO

ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN A (continued):

BASIC ACCIDENT AND SICKNESS BENEFITS (continued):

OUTPATIENT EXPENSE:

Day Surgery Facility/Miscellaneous

When scheduled surgery is performed in a Hospital or outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding Physiotherapy or take home drugs and medicines). Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the most recent edition of the Outpatient Surgical Facility Charge Index.

Covered Percentage	100%	80%

Hospital Emergency Room and Non-Scheduled Surgery

For use of Hospital Emergency Room, including operating room, laboratory and x-ray examinations, supplies.

Co-pay Amount per visit	$250	$250
Covered Percentage	100%	80%

Services must be rendered within 72 hours of the Accident.

For Wellness Services (not otherwise covered under Preventive Services)

Coverage includes services that promote health and well –being not otherwise covered under this Policy but is not limited to, routine Doctor's visits, routine physical examinations, preventive services, immunizations (other than immune titers), routine testing, screenings, and services related to routine physical examinations.

Covered Percentage*	100%	N/A

*When the services above are rendered at the Student Health Center, the benefit will be payable at 100%.

For Benefits for Preventive Services mandated by the Patient Protection and Affordable Care Act

Covered Percentage:	100%	N/A

For Laboratory and X-ray Examinations (not otherwise covered under Preventive Services)

Covered Percentage	100%	80%

For CAT Scan/MRI

Covered Percentage	100%	80%

For Radiation Therapy and Chemotherapy

Covered Percentage	100%	80%

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO

ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN A (continued):

BASIC ACCIDENT AND SICKNESS BENEFITS (continued):

OUTPATIENT EXPENSE (continued):

**For Durable Medical Equipment* **		
Covered Percentage	100%	80%

*Benefits are payable only upon Doctor's written prescription.
**Replacement not covered.

For Orthopedic Braces and Appliances* **		
Covered Percentage	100%	80%

*Benefits are payable only upon Doctor's written prescription.
**Replacement not covered except for repair or replacement that is required by a changed condition due to Injury or Sickness.

For Immune Titers (not otherwise covered under Preventive Services)

Co-pay Amount per visit:		
Student Health Center:	$10	N/A
Outside Student Health Center:	N/A	N/A
Covered Percentage:		
Student Health Center:	100%	N/A
Outside Student Health Center:	N/A	N/A

For Injections*		
Injury		
Covered Percentage	100%	80%
Sickness**		
Covered Percentage	100%	80%

*Benefits are payable when administered in the Doctor's office.
**Benefits payable for contraception injections only, not subject to Deductibles or Co-pays.

For Diagnostic Services and Medical Procedures performed by the Doctor (other than Doctor's visits, Physiotherapy, x-rays and lab procedures) (not otherwise covered under Preventive Benefits).		
Covered Percentage	100%	80%
For Rehabilitative Care		
For Physiotherapy		
Covered Percentage	100%	80%
Occupational Therapy		
Covered Percentage	100%	80%

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO
ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN A (continued):		
BASIC ACCIDENT AND SICKNESS BENEFITS (continued):		
***OUT OF HOSPITAL DOCTOR'S FEES EXPENSE:**		
Co-pay Amount per visit	$25	$25
Covered Percentage	100%	80%
*Limited to one visit per day per Doctor. *Benefits do not apply when related to surgery or Physiotherapy.		
CONSULTANT'S FEES EXPENSE:		
Co-pay Amount per visit	$25	$25
Covered Percentage	100%	80%
AMBULANCE EXPENSE:		
Covered Percentage	100%	100%
DENTAL TREATMENT EXPENSE (Injury Only)		
Covered Percentage	80%	80%
Maximum Amount per Tooth	$250	$250
DENTAL TREATMENT EXPENSE (Available at Howard University Outpatient Clinic at the College of Dentistry Only):		
Covered Percentage:	100%	Not Covered
DENTAL TREATMENT EXPENSE FOR IMPACTED WISDOM TEETH:	Included in Surgical Expense	
SECOND SURGICAL OPINION EXPENSE:		
Co-pay Amount per visit	$25	$25
Covered Percentage	100%	80%
PRESCRIBED MEDICINES EXPENSE* **:		
Covered Percentage:	100%	N/A
Co-pay Amount per Prescription – limited to a 30 day supply:		
Generic	$15	N/A
Formulary Brand Name	$30	N/A
Non-Formulary Brand Drug	$55	N/A

*This benefit applies to all prescribed FDA-approved birth control methods. The Co-pay Amount will be waived for prescribed FDA-approved birth control.
**For Injury only, the Co-pays above apply to the Eligible Expenses incurred at a Script Care participating pharmacy only.

HOME HEALTH CARE EXPENSE	See Coverage Provisions	
Covered Percentage	80%	80%
Maximum Number of Visits per Policy Year	100	

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO
ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN A (continued):		
BASIC ACCIDENT AND SICKNESS BENEFITS (continued):		
HOSPICE CARE EXPENSE	See Coverage Provisions	
MATERNITY TESTING EXPENSE	See Coverage Provisions	
MANDATED COVERAGES:		
ORAL ANTI-CANCER MEDICATION	See Coverage Provisions	
SUBSTANCE ABUSE AND MENTAL ILLNESS EXPENSE	See Coverage Provisions	
DIABETES EXPENSE	See Coverage Provisions	
MAMMOGRAPHY AND CERVICAL CYTOLOGICAL SCREENING	See Coverage Provisions	
COLORECTAL CANCER SCREENING	See Coverage Provisions	
BREAST CANCER TREATMENT	See Coverage Provisions	
RECONSTRUCTIVE BREAST SURGERY	See Coverage Provisions	
PROSTATE CANCER SCREENING	See Coverage Provisions	
VOLUNTARY HIV SCREENING TEST EXPENSE	See Coverage Provisions	
EMERGENCY CARE	See Coverage Provisions	
CHILD HEALTH SUPERVISION SERVICES (not otherwise covered under Preventive Services)	See Coverage Provisions	
CLINICAL TRIALS EXPENSE	See Coverage Provisions	
HABILITATIVE SERVICES FOR CHILDREN (not otherwise covered under Preventive Services)	See Coverage Provisions	
NEWBORN HEARING IMPAIRMENT SCREENING (not otherwise covered under Preventive Services)	See Coverage Provisions	

REPATRIATION OF REMAINS EXPENSE BENEFIT:
Maximum Amount $25,000*

*In no event will the Maximum Amount payable for Repatriation of Remains exceed $25,000 when combined with the amount paid for Medical Evacuation Expense Benefit.

MEDICAL EVACUATION EXPENSE BENEFIT:
Maximum Amount $25,000*

*In no event will the Maximum Amount payable for Medical Evacuation exceed $25,000 when combined with the amount paid for Repatriation of Remains Expense Benefit.

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO
ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN B:		
BASIC ACCIDENT AND SICKNESS BENEFITS:		
Basic Aggregate Maximum Benefit per Injury or Sickness per Policy Year	$500,000	
NEEDLESTICK AND SPLATTER EXPENSE		
Covered Percentage	100%	100%
HOSPITAL EXPENSE:		
Daily Room and Board Maximum:	Average Semi-private Rate	
Maximum Amount per Day		
Injury	N/A	N/A
Sickness	N/A	$200
Covered Percentage Room and Board	100%	100%
Covered Percentage Hospital Miscellaneous	100%	100%
Intensive Care Unit	Included in the Daily Room and Board Maximum	
Pre-Admission Testing (Hospital Confinement must occur within 3 days of the testing)		
Covered Percentage	100%	100%
Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is: (a) rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service.		
Injury		
Covered Percentage	100%	100%
Sickness		
Covered Percentage	N/A	N/A
Physiotherapy during Hospital Confinement		
Covered Percentage	100%	100%
SURGICAL EXPENSE (Inpatient or Outpatient):		
Covered Percentage	100%	100%
Assistant Surgeon (Inpatient or Outpatient)		
Injury		
Covered Percentage	100%	100%
Sickness		
Covered Percentage	N/A	N/A
Anesthesia (Inpatient or Outpatient)		
Covered Percentage	100%	100%

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO

ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN B (continued):

BASIC ACCIDENT AND SICKNESS BENEFITS (continued):

IN-HOSPITAL DOCTOR'S FEES EXPENSE*

Covered Percentage	100%	100%

*Benefits do not apply when related to surgery.

OUTPATIENT EXPENSE:

Day Surgery Facility/Miscellaneous

When scheduled surgery is performed in a Hospital or outpatient facility or ambulatory surgical center, including: use of the operating room; laboratory tests and x-ray examinations (including professional fees); anesthesia; infusion therapy; drugs or medicines and supplies; therapeutic services (excluding Physiotherapy or take home drugs and medicines). Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the most recent edition of the Outpatient Surgical Facility Charge Index.

Covered Percentage	100%	100%

Hospital Emergency Room and Non-Scheduled Surgery

For use of Hospital Emergency Room, including operating room, laboratory and x-ray examinations, supplies.

Co-pay Amount per visit		
Injury	N/A	N/A
Sickness	$100	$100
Covered Percentage	100%	100%

Services must be rendered within 72 hours of the Accident.

For Wellness Services (not otherwise covered under Preventive Services)

Coverage includes services that promote health and well –being not otherwise covered under this Policy but is not limited to, routine Doctor's visits, routine physical examinations, preventive services, immunizations (other than immune titers), routine testing, screenings, and services related to routine physical examinations.

Covered Percentage	100%	N/A

For Benefits for Preventive Services mandated by the Patient Protection and Affordable Care Act

Covered Percentage:	100%	N/A

For Laboratory and X-ray Examinations (not otherwise covered under Preventive Services)

Covered Percentage	100%	100%

For CAT Scan/MRI

Covered Percentage	100%	100%

For Radiation Therapy and Chemotherapy

Covered Percentage	100%	100%

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO

ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN B (continued):

BASIC ACCIDENT AND SICKNESS BENEFITS (continued):

OUTPATIENT EXPENSE (continued):

For Durable Medical Equipment* **		
Covered Percentage	100%	100%

*Benefits are payable only upon Doctor's written prescription.
**Replacement not covered.

For Orthopedic Braces and Appliances* **		
Covered Percentage	100%	100%

*Benefits are payable only upon Doctor's written prescription.
**Replacement not covered except for repair or replacement that is required by a changed condition due to Injury or Sickness.

For Immune Titers (not otherwise covered under Preventive Services)

Co-pay Amount per visit:		
Student Health Center:	$10	N/A
Outside Student Health Center:	N/A	N/A
Covered Percentage:		
Student Health Center:	100%	N/A
Outside Student Health Center:	N/A	N/A

For Injections*

Injury		
Covered Percentage	100%	100%
Sickness**		
Covered Percentage	100%	100%

*Benefits are payable when administered in the Doctor's office.
**Benefits payable for contraception injections only.

For Diagnostic Services and Medical Procedures performed by the Doctor (other than Doctor's visits, Physiotherapy, x-rays and lab procedures) (not otherwise covered under Preventive Benefits).		
Covered Percentage	100%	100%
For Rehabilitative Care		
For Physiotherapy		
Covered Percentage	100%	100%
Occupational Therapy		
Covered Percentage	100%	100%

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO
ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN B (continued):		
BASIC ACCIDENT AND SICKNESS BENEFITS (continued):		
***OUT OF HOSPITAL DOCTOR'S FEES EXPENSE:**		
Covered Percentage	100%	100%
*Limited to one visit per day per Doctor. *Benefits do not apply when related to surgery or Physiotherapy.		
CONSULTANT'S FEES EXPENSE:		
Covered Percentage	100%	100%
AMBULANCE EXPENSE:		
Covered Percentage	100%	100%
DENTAL TREATMENT EXPENSE (Injury Only)		
Covered Percentage	80%	80%
Maximum Amount per Tooth	$250	$250
DENTAL TREATMENT EXPENSE (Available at Howard University Outpatient Clinic at the College of Dentistry Only):		
Covered Percentage:	100%	Not Covered
DENTAL TREATMENT EXPENSE FOR IMPACTED WISDOM TEETH:	Included in Surgical Expense	
SECOND SURGICAL OPINION EXPENSE:		
Covered Percentage	100%	100%
PRESCRIBED MEDICINES EXPENSE* **:		
Covered Percentage:	100%	N/A
Co-pay Amount per Prescription – limited to a 30 day supply:		
Generic	$10	N/A
Formulary Brand Name	$25	N/A
Non-Formulary Brand Drug	$50	N/A

*This benefit applies to all prescribed FDA-approved birth control methods. The Co-pay Amount will be waived for prescribed FDA-approved birth control.
**For Injury only, the Co-pays above apply to the Eligible Expenses incurred at a Script Care participating pharmacy only.

HOME HEALTH CARE EXPENSE	See Coverage Provisions	
Covered Percentage	80%	80%
Maximum Number of Visits per Policy Year	100	
HOSPICE CARE EXPENSE	See Coverage Provisions	
MATERNITY TESTING EXPENSE	See Coverage Provisions	

SECTION 1 - SCHEDULE OF BENEFITS (PPO/NON-PPO)

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO
ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN B (continued):		
SUPPLEMENTAL ACCIDENT AND SICKNESS BENEFITS:		
Supplemental Aggregate Maximum Benefit Limit per Accident or Sickness per Policy Year	$500,000	
Covered Percentage	80%	80%

After the Basic Aggregate Maximum Amount per Injury or Sickness has been paid under the Plan B – Basic Accident and Sickness Benefits, the Company will pay the Covered Percentage for additional Eligible Expenses incurred up to the Aggregate Maximum Benefit Limit per Injury or Sickness under Plan B - Supplemental Accident and Sickness Benefits. The total combined amount of benefits payable under the Basic Accident and Sickness Benefits and the Supplemental Accident and Sickness Benefits combined may not exceed $1,000,000 per Injury or Sickness per Policy Year.

No benefits will be paid under the Supplemental Accident and Sickness Expense Benefit for:

1) Dental treatment;
2) Hospital Room and Board charges in excess of the average semi-private room rate if PPO provider;
3) Hospital Room and Board and Hospital Miscellaneous charges in excess of $650 per day if Non-PPO provider;
4) Substance Abuse and Mental Illness; or
5) Outpatient physiotherapy.

REPATRIATION OF REMAINS EXPENSE BENEFIT:
Maximum Amount $25,000*

*In no event will the Maximum Amount payable for Repatriation of Remains exceed $25,000 when combined with the amount paid for Medical Evacuation Expense Benefit.

MEDICAL EVACUATION EXPENSE BENEFIT:
Maximum Amount $25,000*

*In no event will the Maximum Amount payable for Medical Evacuation exceed $25,000 when combined with the amount paid for Repatriation of Remains Expense Benefit.

MANDATED COVERAGES:

ORAL ANTI-CANCER MEDICATION	See Coverage Provisions
SUBSTANCE ABUSE AND MENTAL ILLNESS EXPENSE	See Coverage Provisions
DIABETES EXPENSE	See Coverage Provisions
MAMMOGRAPHY AND CERVICAL CYTOLOGICAL SCREENING	See Coverage Provisions
COLORECTAL CANCER SCREENING	See Coverage Provisions
BREAST CANCER TREATMENT	See Coverage Provisions
RECONSTRUCTIVE BREAST SURGERY	See Coverage Provisions
PROSTATE CANCER SCREENING	See Coverage Provisions

COVERAGE	BENEFIT AMOUNT PPO	Non-PPO
ACCIDENT AND SICKNESS EXPENSE BENEFIT - PLAN B (continued):		
MANDATED COVERAGES (continued):		
VOLUNTARY HIV SCREENING TEST EXPENSE	See Coverage Provisions	
EMERGENCY CARE	See Coverage Provisions	
CHILD HEALTH SUPERVISION SERVICES (not otherwise covered under Preventive Services)	See Coverage Provisions	
CLINICAL TRIALS EXPENSE	See Coverage Provisions	
HABILITATIVE SERVICES FOR CHILDREN (not otherwise covered under Preventive Services)	See Coverage Provisions	
NEWBORN HEARING IMPAIRMENT SCREENING (not otherwise covered under Preventive Services)	See Coverage Provisions	

SECTION 2 - DEFINITIONS

Whenever used in this Policy:

"**Accident**" means an occurrence which
(a) is unforeseen;
(b) is not due to or contributed to by Sickness or disease of any kind; and
(c) causes Injury.

"Act" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

"Actual Charge" means the charge for the covered service by the provider who furnishes it.

"Allowable Charges" means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

"**Complications of Pregnancy**" means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
(a) acute nephritis or nephrosis; or
(b) eclampsia; puerperal infection; or
(c) RH Factor problems; or
(d) severe loss of blood requiring transfusion; or
(e) cardiac decompensation or missed abortion; or
(f) similar conditions as severe as these.

Not included are
(a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy;
(b) morning sickness;
(c) hyperemesis gravidarum and pre-eclampsia; and
(d) similar conditions not medically distinct from a difficult pregnancy. Complications of Pregnancy also include:
    1. non-elective cesarean section; and
    2. termination of an ectopic pregnancy; and
    3. spontaneous termination when a live birth is not possible. (This does not include voluntary or elective abortion.)

"Coinsurance" means the percentage of the Eligible Expense payable by the Covered Person under this Policy.

"Co-pay" means the initial dollar amount payable by the Covered Person for an Eligible Expense at the time service is rendered.

"**Covered Percentage"** means the percentage of the Eligible Expense that is payable as a benefit under this Policy.

"**Covered Person**" means a Covered Student and his or her Dependent(s) insured under this Policy.

"**Covered Student**" means a student of this Policyholder who is insured under this Policy.

SECTION 2 - DEFINITIONS

"**Dependent**" means: (a) the Covered Student's Spouse residing with the Covered Student; and (b) the Covered Student's child by blood or law who: (1) is under age 26 years of age; (2) has no dependent of his or her own; (3) is enrolled as a full-time student at an accredited public or private institution of higher education; and (4) is not provided coverage, or eligible to receive coverage, as a named subscriber, insured, enrollee, or covered person under any other group health plan or individual health plan, or entitled to benefits under Title XVIII of the Social Security Act, approved July 30, 1965 (Pub. L. 89-871; 42 U.S.C. § 1395 et seq.), at the time coverage under this Policy becomes effective.

The term "child" includes:
(a) a Covered Student's legally adopted child;
(b) child who has been placed in the Covered Student's home pending adoption procedures, from the moment of placement as certified by the agency making the placement; and
(c) a Covered Student's step-child if such child resides with the Covered Student and depends on the Covered Student for full support.

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

The term "child" includes a child of the Covered Student who is a noncustodial parent. In such case, the Company will:
(a) provide information to the custodial parent as may be necessary for the child to obtain benefits applicable to Covered Dependents under this Policy;
(b) permit the custodial parent or the health care provider, with the custodial parent's approval, to submit claims for Eligible Expenses without the approval of the noncustodial parent; and
(c) make payments on claims submitted to the custodial parent, health care provider or the state medicaid agency, whichever is applicable.

The "child" of a Covered Student will not be denied enrollment under this Policy because he or she:
(a) was born out of wedlock;
(b) is not claimed as a dependent on the Covered Student's federal tax return; or
(c) does not reside, other than a step-child, with the Covered Student or in this Policy's service area.

The term "child" also includes a child for whom the Covered Student is required by a court or administrative order to provide coverage. In the event such is the case, the Covered Student may apply to insure the child, if he or she is otherwise eligible for coverage, without regard to any enrollment requirements. Insurance will become effective for such child on the date the Company receives the request. If the Covered Student is eligible for dependent insurance but fails to apply to insure the child in accordance with the court or administrative order, such child will become insured on the date the Company receives the written request to insure the child from the child's other parent, or the District of Columbia agency administering either the Medicaid program or the child support enforcement program pursuant to Title IV-D of the Social Security Act (88 Stat. 2351; 42 U.S.C. §§ 652 through 669).

"**Doctor**" as used herein means:
(a) legally qualified physician licensed by the state in which he or she practices; and
(b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and
(c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term "Doctor" does not include a Covered Person's Immediate Family Member.

SECTION 2 - DEFINITIONS

"**Durable Medical Equipment**" consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for therapeutic use.

The following items are not considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.

"**Elective Treatment**" means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage.

Elective treatment includes, but is not limited to: vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; botox injections; treatment of infertility and routine physical examinations.

"Eligible Expense" as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury:

(a) not in excess of the Reasonable and Customary charges; or
(b) not in excess of the charges that would have been made in the absence of this coverage;
(c) with respect to the Preferred Provider, is the Allowable Charge;
(d) is the negotiated rate, if any;
(e) and incurred while this Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits provision.

"**Emergency Medical Condition**" means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of medicine and health, to result in: (a) placing the health of the person afflicted with such condition in serious jeopardy; (b) serious impairment to such person’s bodily functions; (c) serious impairment or dysfunction of any bodily organ or part of such person.

“Emergency Services” means, with respect to an Emergency Medical Condition:
(a) a medical screening examination (as required under section 1867 of the Social Security Act, 42, U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

SECTION 2 - DEFINITIONS

"Essential Health Benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services,; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Experimental/Investigational" means a drug, device or medical care or treatment that meets the following:

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
(b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;
(c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;
(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, it efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

"**Hospital**" means a facility which meets all of these tests:

(a) it provides in-patient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and major surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental Illness; or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; and (b) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

"Hospital Confinement/Hospital Confined" means a stay of at least 18 consecutive hours or for which a room and board charge is made.

SECTION 2 - DEFINITIONS

“Immediate Family Member(s)” means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

“Injury” means bodily injury due to an Accident which:

(a) results solely, directly and independently of disease, bodily infirmity or any other causes;
(b) occurs after the Covered Person’s effective date of coverage; and
(c) occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

"**Intensive Care Unit**" means a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.

“Medical Necessity/Medically Necessary" means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:

(a) it is provided only as a convenience to the Covered Person or provider; or
(b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or
(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
(d) it is Experimental/Investigational or for research purposes; or
(e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or
(f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or

(g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or
(h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

The fact that any particular Doctor may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply Medically Necessary or covered by the Policy.

"**One Sickness**" means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.

"Orthopedic Brace and Appliance” means a supportive device or appliance used to treat a Sickness or Injury.

"**Personal Item**" is one which is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

“Physiotherapy” means any form of the following administered by a Doctor for treatment of Sickness or Injury: physical or mechanical; diathermy; ultra-sonic therapy; heat treatment in any form; or manipulation or massage.

SECTION 2 - DEFINITIONS

"**Policy Year**" means the period of time measured from the Effective date to the Termination Date as shown in the Schedule of Benefits.

"Pre-Admission Testing" means diagnostic tests and services ordered by the attending Doctor as appropriately related to the care and treatment of the Covered Person's condition in anticipation of a scheduled Hospital Confinement and required prior to surgery; a Hospital bed and operating room have been reserved before the tests are made; and the surgery is performed within 3 days after the tests; and the Covered Person is physically present for the tests. In the event pre-admission testing is ordered by the attending Doctor and the Hospital Confinement and/or surgery are subsequently canceled, benefits for pre-admission testing and services already performed will be covered and benefits will be payable under this Policy based on the available coverage.

No benefit shall be payable in excess of the benefits that would have been provided under the Policy had the Covered Person received those tests while confined in the Hospital as a resident bed-patient.

"Pre-Existing Condition" means a condition, whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the Covered Person's effective date of coverage under this Policy. Genetic information shall not be treated as a pre-existing condition in the absence of a diagnosis of the condition related to such information.

"Preventive Services" mandated by the Patient Protection and Affordable Care Act and, in addition to any other preventive benefits described in the Policy or Certificate, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:

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, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
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 Covered Person involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

"**Reasonable and Customary**" means the charge, fee or expense which is the smallest of:

(a) the actual charge;
(b) the charge usually made for a covered service by the provider who furnishes it;
(c) the negotiated rate, if any; and
(d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

"Geographic area" means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

SECTION 2 - DEFINITIONS

"**Sickness**" means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

"**Sound Natural Teeth**" means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

"Spouse" means the person to whom the Covered Person is legally married.

"**Student Health Center**" means any organization, facility or clinic owned, operated, maintained or supported by this Policyholder.

SECTION 3 – EFFECTIVE DATE OF COVERAGE

Policy Effective Date. This Policy begins on this Policy Effective Date shown in the signed Application at 12:01 AM Standard Time at the address of this Policyholder where this Policy is delivered.

Eligible Persons
Student:
Each student, as determined by the school in which he or she is enrolled, is eligible for coverage under this Policy and will be automatically enrolled for Plan A. At initial time of enrollment, any student automatically enrolled for Plan A may upgrade to Plan B by enrolling on a form provided for that purpose.

An eligible student must actively attend classes at this Policyholder's school for at least the first 31 days of the period for which he or she is enrolled. Except in the case of withdrawal due to Sickness or Injury, any student withdrawing from school during the first 31 days of the period for which he or she is enrolled will not be covered under this Policy and a full refund of premium will be made less any claims paid. Students who withdraw after such 31 days will remain covered under this Policy and no refund will be made. Home study, correspondence, Internet and television (TV) courses do not fulfill the Eligibility requirements that the student actively attended classes. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that this Policy eligibility requirements have been met. If it is discovered that this Policy eligibility requirements have not been met, the Company's only obligation is to refund premium less any claims paid.

Dependent:
A Dependent may become eligible for coverage under this Policy only when the student becomes eligible; or within 31 days of marriage, birth, adoption or arrival in the U.S.

Covered Person's Effective Date
Covered Student:
The coverage of an eligible Student who enrolls for coverage under this Policy shall take effect on the latest of the following dates: (1) this Policy Effective Date; (2) the day after the date for which the first premium for the Covered Student's coverage is received by the Company; or (3) the date the Policyholder's term of coverage begins; (4) the date the Student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits.

Covered Dependent
A covered Dependent's coverage shall take effect on the later the following dates: (1) the date the coverage for the Covered Student becomes effective; or (2) the date the Dependent is enrolled for coverage, provided premium is paid when due.

A newborn child shall be insured for Injury or Sickness, including the necessary care and treatment of premature birth and medically diagnosed congenital defects and birth abnormalities and the circumcision of a newborn male as well as nursery care for newborn well-baby furnished any infant from the moment of birth for an initial period of 31 days. To continue the insurance beyond this initial 31 day period, the Covered Student must notify the Company of the birth in writing and pay any additional premium required for the child's insurance within the 31 day period. Otherwise, insurance terminates at the end of the 31 day period.

Coverage of an adopted child becomes effective on the earlier of: (a) the date of placement for the purpose of adoption; or (b) the date of entry of an order granting the Covered Student custody of the child for purposes of adoption. Such adopted child shall be insured for Injury or Sickness, including the necessary care and treatment of premature birth and medically diagnosed congenital defects, birth abnormalities and nursery care. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. The Covered Student must notify the Company in writing within 31 days of such adoption and pay any additional premium required for the adopted child's insurance to continue beyond such 31 day period. Otherwise insurance terminates at the end of the 31 day period.

SECTION 3 – EFFECTIVE DATE OF COVERAGE

This Policyholder agrees to submit to the Company within 60 days after the effective date of each Covered Person's insurance: (1) the name of each person enrolled for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such Covered Person. The insurance of those Covered Persons whose names and premiums were received more than 60 days after the date the insurance would have become effective will take effect on the date such name and premium is received by the Company or its authorized representative except as provided in the previous paragraph.

Continuously insured means a person has been continuously insured under this Policy and prior Health Insurance policies issued to the Policyholder. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for Expenses payable under prior policies in the absence of this Policy. Previously insured Dependents and students must re-enroll for coverage in order to avoid a break in coverage to maintain coverage for conditions which existed in prior Policy Years. Once a break in continuous insurance occurs, the definition of Pre-Existing Condition will apply in determining coverage of any condition which existed during such break.

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS, CONTINUATION OF COVERAGE

TERMINATION OF POLICY

The Company may terminate this Policy by giving 30 days advance notice in writing to this Policyholder. This Policy may, at any time, be terminated by mutual written consent of the Company and this Policyholder. This Policy terminates automatically on the earlier of: (1) this Policy Termination Date shown in the Schedule of Benefits; or (2) the premium due date if premiums are not paid when due. Termination takes effect at 11:59 p.m. Standard Time at this Policyholder's address on the date of termination.

This Policy is issued for this Policy Term stated in the Schedule of Benefits on the Effective Date of this Policy. If this Policyholder desires to continue coverage, a new Policy will be issued for a new Policy Term, subject to the then current underwriting requirements.

TERMINATION OF STUDENT COVERAGE

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:

(a) the date this Policy terminates;
(b) the last day for which any required premium has been paid;
(c) the date on which the Covered Student withdraws from the school because of:
    (1) entering the armed forces of any country (Premiums will be refunded on a pro-rata basis (less any claims paid) when written request is made.); or
    (2) withdrawal from school during the first 31 days of the period for which enrollment was made.

If withdrawal from the Policyholder's school is for other than (1) or (2) above, no premium refund will be made. Students, including those who withdraw from the Policyholder's school during the first 31 days due to Injury or Sickness, will be covered for this Policy term for which they are enrolled and for which premium has been paid.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

Note: Each Student must re-enroll each year even in the event this Policy is renewed.

TERMINATION OF DEPENDENT COVERAGE

Insurance for a Covered Student's Dependent will end when insurance for the Covered Student ends.

Insurance for Dependents will also terminate on the first premium due date after any of the following events occur:

(a) the last day of the month in which status as a Dependent ends;
(b) Dependent insurance is deleted from this Policy (any unearned premium will be refunded); or
(c) at the end of the last period for which any required premium has been paid;
(d) in the event of a court or administrative order requiring coverage of a Dependent child, the date the court or administrative order is no longer in effect; or the date the Dependent child's comparable coverage provided through another carrier becomes effective. Satisfactory written evidence of this must be provided to the Company.

Insurance may be continued for incapacitated dependent children who reach the age at which insurance would otherwise cease. The dependent child must be:

(a) chiefly dependent upon the Covered Student for support; and
(b) incapable of self-sustaining employment because of mental or physical handicap.

Proof of the incapacity and dependency must be furnished to the Company by the Covered Student within 31 days after insurance would terminate because of age and as often as the Company may subsequently request but not more often than once a year after the 2 year period following the child's attainment of the limiting age.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS, CONTINUATION OF COVERAGE

EXTENSION OF BENEFITS.

PLAN A: If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital Confinement. Such benefits will be payable until the earliest of: (1) the date the Hospital Confinement ends; (2) the end of the 90 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

PLAN B: If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital Confinement. Such benefits will be payable until the earliest of: (1) the date the Hospital Confinement ends; (2) the end of the 12 month period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under this Policy or any other health insurance policy in the ensuing term of coverage.

COVERAGE FOR DEPENDENT CHILD ON MEDICAL LEAVE OF ABSENCE. Coverage for a Dependent child who is a full-time student, as defined in this Policy, shall continue for a covered Dependent child who takes a leave of absence from school due to illness for a period of twelve months from the last day of attendance in school. In no event will coverage continue beyond the date or age at which coverage would otherwise terminate.

CONTINUATION OF COVERAGE. The right to continue coverage under this Policy is available to a Student who is no longer an Eligible Person. Written request for continuation for the Student and payment of premium must be received by the Company within 31 days following the date coverage under this Policy terminates. If continuous coverage is maintained, coverage may be continued for up to an additional 6 months. In no event will this option to continue coverage be extended beyond the number of months initially requested. Continuation of coverage will be subject to the terms and conditions of the Policy in effect on the date the Covered Student becomes eligible under this option.

CERTIFICATES OF CREDITABLE COVERAGE. The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under this Policy is terminated. In addition, Certificates shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under this Policy. Such issuance will occur within a reasonable time.

SECTION 5 - GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. This Policy, the Application and any attached papers make up the entire contract between this Policyholder and the Company. In the absence of fraud or intentional misrepresentation of a material fact, all statements made by this Policyholder or any Covered Person will be deemed representations and not warranties. No written statement made by a Covered Person will be used in any contest unless a copy of the statement is furnished to the Covered Person or his or her beneficiary or personal representative.

No change in this Policy shall be valid unless approved by an officer of the Company. The approval must be noted on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

INCONTESTABILITY. The validity of this Policy will not be contested after it has been in force for three year(s) from this Policy Effective Date, except as to nonpayment of premiums.

PREMIUMS. The Company sets the premiums that apply to the coverage provided under this Policy. Those premiums are shown in a notice given to this Policyholder with or prior to delivery of this Policy. The Company has the right to adjust the premium rate when the terms of this Policy are changed. This Policyholder will be given notice of such premium adjustment at least 30 days before the date it is to take effect unless the change in Policy terms is to take effect before the 30 days.

RENEWAL OF POLICY. This Policy is issued for this Policy Term shown in the Schedule of Benefits. If this Policyholder wishes to continue coverage, the Company will issue a new Policy for a new Policy Term, subject to the then current underwriting requirements.

GRACE PERIOD. The premium due date will be negotiated by the Company and this Policyholder. The grace period of thirty-one days will be granted for the payment of each premium falling due after the first premium. During that period, this Policy shall continue in force. This Policyholder shall be liable to the Company for the payment of the premium for the period this Policy continues in force.

NOTICE OF CLAIM. Written notice of claim must be given to the Company within 20 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to the Company at Summit America Insurance Services, LC, 7400 College Boulevard, Suite 100, Overland Park, KS 66210, with information sufficient to identify the Covered Person, shall be deemed notice to the Company.

CLAIM FORMS. Upon receipt of a written notice of claim, the Company will give the claimant such forms as are usually given by the Company for filing proofs of loss. If such forms are not given within 15 days after the receipt of such notice, the claimant can fulfill the terms of this Policy as to proof of loss by giving written proof of: (a) the occurrence of the loss; and (b) the nature of the loss; and (c) the extent of the loss.

PROOFS OF LOSS. Written proof of loss must be given to the Company within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible and in no event, except in the absence of legal capacity of the claimant, later than one year from the time proof is otherwise required.

TIME OF PAYMENT OF CLAIMS. Benefits payable under this Policy will be paid as they accrue and immediately upon receipt of due written proof of such loss by the Company, but in no event more than 30 days from receipt of proof of loss. If benefits are not paid by the end of the 30 day period after final proof of loss is given, the Company must pay a penalty.

The penalty shall be the interest at a monthly rate of:
(a) one and one-half percent from the 31st day through the 60th day;
(b) two percent from the 61st day through the 120th day; and
(c) two and one-half percent after the 120th day.

The interest penalty above will not apply if the Company:
(a) notifies the Covered Person within 30 days after receipt of proof of loss that the legitimacy of such proof of loss or the appropriate benefit amount is in dispute;
(b) states, in writing, to the Covered Person the specific reasons why the legitimacy of the proof of loss, the appropriate benefit amount is in dispute; and
(c) pays any undisputed portion of the benefit amount within 30 days of the receipt of proof of loss.

PAYMENT OF CLAIMS. Upon receipt of due written proof of death, payment for loss of life of a Covered Person will be made, in equal shares, to the survivors in the first surviving class of those that follow: the Covered Person's (1) Spouse; (2) children; (3) parents; (4) brothers and sisters. If no class has a survivor, the beneficiary is the Covered Person's estate. Benefits for Accidental Dismemberment will be payable to the Covered Person.

Benefits payable for covered health care Eligible Expenses incurred by a Covered Person are payable directly to the provider, at the option of the Company, unless the Covered Person requests otherwise in writing not later than the time of filing a proof of loss. If the Covered Person has already paid the Eligible Expenses, the benefit for those Eligible Expenses will be paid to the Covered Student. If the Covered Student dies before all benefits due have been paid, the amount still payable will be made to the Covered Student's estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

ASSIGNMENT. This Policy is non-assignable.

PHYSICAL EXAMINATION AND AUTOPSY. The Company at its own expense has the right to have a Doctor examine a Covered Person when and so often as it deems reasonably necessary while there is a claim pending under this Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on this Policy within sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three (3) years from the time that proof of loss was required to be furnished.

MISSTATEMENT OF AGE. If premiums for the Covered Persons are based on age and the Covered Person has misstated his or her age, there will be a fair adjustment of premiums based on his or her true age. If the benefits for which the Covered Person is insured are based on age and the Covered Person has misstated his or her age, there will be an adjustment of said benefit based on his or her true age. The Company may require satisfactory proof of age before paying any claim.

RECORDS MAINTAINED. This Policyholder shall maintain records of each person covered. The records shall show all data that is needed to administer this Policy.

SECTION 5 - GENERAL PROVISIONS

EXAMINATION AND AUDIT. The Company shall be allowed to examine and audit this Policyholder's books and records which pertain to this Policy at reasonable times. The Company must also be allowed to do this within three (3) years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

CONFORMITY WITH STATE STATUTES. Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

POLICY ERROR. Clerical errors, whether by this Policyholder or the Company, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect nor extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in this Policy.

NOT IN LIEU OF WORKERS' COMPENSATION. This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

RIGHT OF RECOVERY. As a condition to receiving benefits under this policy, the Covered Person (or, if he or she is deceased, an authorized representative of the Covered Person) agrees, except as may be limited or prohibited by applicable law:

(a) to reimburse the Company for any such benefits paid to or on behalf of the Covered Person, if such benefits are recovered, in any form, from any Third Party or Coverage; and
(b) if the Covered Person is a minor or is not competent to make this agreement, the legal guardian of the Covered Person's property makes the agreement on the Covered Person's behalf as a condition to receiving benefits under this Policy on behalf of the Covered Person. If the Covered Person has no guardian for his or her property, the person or persons who, in the Company's opinion, have assumed the custody and support of the minor or responsibility for the incompetent person's affairs make the agreement on the Covered Person's behalf as a condition to receiving such benefits under this Policy on behalf of the Covered Person.

SUBROGATION. In the event any payments for benefits provided to a Covered Person are because of an Injury or Sickness caused by a Third Party's wrongful act or negligence, the Company, to the extent of that payment, will be subrogated to any recovery or right of recovery the Covered Person has against that Third Party, provided:
(a) the Covered Person is entitled to payment for Hospital, surgical or medical services as the result of a Third Party settlement or court judgment; and
(b) such settlement or judgment specified an amount or portion of payment that represents payment for such benefits; and
(c) the Company has paid benefits to the Covered Person under this Policy for the same services or benefits covered by the settlement or judgment.

The Covered Person agrees to make a decision on pursuing a claim against a Third Party within 30 days of the date the Company requires that the Covered Person provide Notice of Claim for the Injury or Sickness for which benefits under this Policy are sought and to notify the Company of his or her decision within such 30 day period.

In the event the Covered Person decides not to pursue payment of claim against such Third Party, the Covered Person:
(a) authorizes the Company to pursue, sue, compromise or settle any such payment of claim in the name of the Covered Person;
(b) authorizes the Company to execute any and all documents necessary; and
(c) agrees to cooperate fully with the Company in the prosecution of any such payment of claim.

If the Company exercises its rights under this provision, it will recover no more than the amount paid under this Policy for such benefits. The Covered Person will execute and deliver such instruments and papers which may be needed to secure the rights described above.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of a Covered Person against any Third Party or coverage.

"Subrogation" means the Company's right to recover any benefit payments made under this plan:

(a) because of an Injury or Sickness to a Covered Person caused by a Third Party's wrongful act or negligence; and

(b) which become recoverable from the Third Party or the Third party's insurer.

The Company's right of subrogation will not be enforced until the Covered Person has been made whole, as determined by a court of law, as a result of Injury or Sickness.

"Third Party" means any person or organization other than the Company, this Policyholder or the Covered Person.

This provision will not apply if it is prohibited by law.

SECTION 6 – COVERAGE DESCRIPTIONS

All coverages of this Policy are shown in the Schedule of Benefits. The coverages are described and governed by the pages attached to and made a part of this Policy.

STUDENT ACCIDENT INSURANCE PROVISIONS CONCERNING
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Company will pay the benefit below for Injuries to a Covered Person:
(a) caused by an Accident which happens while covered by this Policy; and
(b) which directly, and from no other cause, result in any of the losses listed below within 180 days of the Accident that caused the Injury.

The amount of this benefit is shown in the table below.

For Loss of	**Percentage of Maximum Amount**
Life	100%
Both Hands or Both Feet	100%
Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and the Sight of One Eye	100%
One Foot and the Sight of One Eye	100%
One Hand or One Foot	100%
The Sight of One Eye	100%

"Loss" of a hand or foot means complete severance through or above the wrist or ankle joint. “Loss” of sight of an eye means the total, irrevocable loss of the entire sight in that eye.

“Severance” means the complete separation and dismemberment of the part from the body.

If a Covered Person suffers more than one loss as a result of the same Accident, the Company will pay only for the loss with the largest benefit.

The exclusions below are in addition to the **SECTION 7 – Exclusions and Limitations**. No benefits will be payable for any Loss caused by:
(a) ptomaine; disease, infirmity or treatment of same; or
(b) bacterial infection except when introduced through a visible wound caused by an Accident.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

When, by reason of Injury or Sickness, a Covered Person incurs Eligible Expenses covered by the Accident and Sickness Expense Benefit provisions which follow, the Company will pay for the Eligible Expense incurred in excess of the Deductible Amount, if applicable. Benefits are paid in accordance with the allocations shown for the Accident and Sickness Expense Benefits in the Schedule of Benefits. The Company will not pay more than the applicable Aggregate Maximum Amount as a result of any one Accident or One Sickness.

The applicable Aggregate Maximum Benefit and Deductible Amount are shown in the Schedule of Benefits.

Expenses for Elective Treatment or elective surgery will not be covered except as specifically provided elsewhere in this Policy.

If benefits under this coverage is payable under more than one provision under this Policy, then benefits will be provided only under the provision providing the greater benefit.

This provision is subject to all the terms of this Policy.

NEEDLESTICK AND SPLATTER EXPENSE

If a Covered Person incurs Eligible Expense because he or she is pricked by a needle or blood is splashed in his or her eyes, the Company will pay the Covered Percentage of the Eligible Expenses for preventive measures taken in the Doctor's office, Hospital or outpatient facility.

The Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

HOSPITAL EXPENSE

Hospital Expenses will be paid as follows:

Part A. Hospital Room and Board Expense - When, by reason of Injury or Sickness, a Covered Person requires Hospital Confinement, the Company will pay the Covered Percentage of the Hospital room and board expense incurred for the period of such confinement. However, the covered room and board expense does not include any charge in excess of the Daily Room and Board Maximum.

Part B. Miscellaneous Hospital Expense - "Miscellaneous Hospital Expense" includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays, (including professional fees); oxygen tent; drugs, medicines (excluding take-home drugs), dressings; and other Medically Necessary and prescribed Hospital Expenses.

The Company will pay the Covered Percentage of the Miscellaneous Hospital Expense incurred by the Covered Person during the period of Hospital Confinement for which benefits are payable under Part A.

BENEFITS FOR MATERNITY

When a Covered Person is confined to a Hospital as a resident inpatient for childbirth, the Company will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be less than:

(a) 48 hours after a non-cesarean delivery; or
(b) 96 hours after a cesarean section;

for the mother and the newborn infant(s) unless an earlier discharge occurs. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. The Company will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Doctor. Any decision made to shorten the inpatient stay described in (a) or (b) above must be made by the attending health care provider and the mother.

In the event such earlier discharge occurs, coverage will be available for post-delivery care within the time minimums in accordance with the medical criteria outlined in the most current version of or an official update to the Guidelines for Perinatal Care prepared by the American Academy of Pediatrics and the American college of Obstetricians or the Standards for Obstetric-Gynecologic Services prepared by the American college of Obstetricians and Gynecologists. Post-delivery care may be delivered in the Covered Person’s home or in a provider’s office, as determined by the Doctor in consultation with the mother.

At-home post-delivery care may be provided by a registered professional nurse, Doctor, nurse practitioner, nurse-midwife or Doctor assistant experienced in maternal and child health and will include:

(a) parent education;
(b) assistance and training in breast or bottle feeding; and
(c) the performance of any Medically Necessary and clinically appropriate tests, including the collection of an adequate sample for hereditary and metabolic newborn screening.

The Daily Room and Board Maximum and the Covered Percentage are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

SURGICAL EXPENSE

Surgical Expense will be paid as follows:

Part A. When, by reason of Injury or Sickness, a Covered Person requires surgery on an inpatient or outpatient basis, the Company will pay the Covered Percentage of the Eligible Expense incurred in connection with such surgery. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

DEFINITIONS

"Surgical Expense" means charges by a Doctor for:

(a) a surgical procedure;
(b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and
(c) usual postoperative treatment.

"Surgical procedure" means:

(a) a cutting procedure;
(b) suturing of a wound;
(c) treatment of a fracture;
(d) reduction of a dislocation;
(e) radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor;
(f) electrocauterization;
(g) diagnostic and therapeutic endoscopic procedures;
(h) injection treatment of hemorrhoids and varicose veins;
(i) an operation by means of laser beam;
(j) casting;
(k) removal of a foreign body;
(l) drainage or aspiration;
(m) implant;
(n) catheter placement;
(o) microsurgery.

BENEFITS

The benefit will be equal to the amount determined by multiplying the Eligible Expenses incurred by the Covered Percentage shown in the Schedule of Benefits.

When Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures are performed.

SURGICAL EXPENSE (continued)

Part B. If, in connection with such surgery, the Covered Person requires the services of an anesthetist, who is not employed or retained by the Hospital in which the surgery is performed, the benefit will be equal to the amount determined by multiplying the Eligible Expense incurred by the applicable Covered Percentage shown in the Schedule of Benefits.

Part C. If, in connection with such surgery, the Covered Person requires the services of an Assistant Surgeon, the benefit will be equal to the amount determined by multiplying the Eligible Expense incurred, by the applicable Covered Percentage shown in the Schedule of Benefits.

The applicable Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

IN-HOSPITAL DOCTOR'S FEES EXPENSE

When, by reason of Injury or Sickness, a Covered Person is confined to a Hospital and requires the services of a Doctor other than a Doctor who performed surgery on, or administered anesthesia to, the Covered Person, the Company will pay the Covered Percentage of the Eligible Expense incurred for such. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

OUTPATIENT EXPENSE

Outpatient Expenses will be paid as follows:
If, by reason of Injury or Sickness, a Covered Person requires the use of the services listed in the Schedule of Benefits for this coverage, the Company will pay the Covered Percentage of the Eligible Expenses incurred in excess of the Co-pay Amount, if applicable. The Eligible Expenses must be incurred by the Covered Person is insured for these benefits.

The Covered Percentage and Co-pay Amount are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

OUT OF HOSPITAL DOCTOR'S FEES EXPENSE

Subject to the Exception below:

If, by reason of Injury or Sickness, a Covered Person requires the services of a Doctor while not confined as a resident bed-patient in a Hospital, the Company will pay the Covered Percentage of the Eligible Expenses incurred in excess of the Co-pay Amount, if applicable. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

This coverage includes benefits for annual routine gynecological/obstetrical care.

This coverage includes benefits for outpatient contraceptive services, including consultations, examinations, procedures and medical services directly related to the use of contraceptive methods to prevent unplanned pregnancy.

EXCEPTION:

If the services are in connection with surgery and the Doctor is the surgeon who performed the surgery, no benefits are payable under this provision.

The Covered Percentage and Co-pay Amount are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

CONSULTANT'S FEES EXPENSE

If a Covered Person, as a result of an Injury or Sickness, requires the services of a Consultant, the Company will pay the Covered Percentage of the Eligible Expense incurred in excess of the Co-pay Amount, if applicable, for such services. Such service must be requested and ordered by the attending Doctor. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The Covered Percentage and Co-pay Amount are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

AMBULANCE EXPENSE

When, by reason of Injury or Sickness, a Covered Person requires the use of a professional ambulance in an emergency, the Company will pay the Covered Percentage of the Eligible Expenses incurred.

“Ambulance” means a vehicle licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for Covered Persons who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care.

Emergency transportation includes ambulance services provided by ground or by air.

The Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

DENTAL TREATMENT EXPENSE

If a Covered Person incurs Eligible Expenses for services of a legally qualified dentist or dental surgeon for treatment made necessary by Injury to Sound Natural Teeth, the Company will pay the Covered Percentage of the Eligible Expenses up to the Maximum Amount per Tooth shown in the Schedule of Benefits.

The Covered Percentage and Maximum Amount per Tooth are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only)

Dental Expense will be paid as follows:
When a Covered Person incurs Eligible Dental Expenses for: basic services; preventive services; diagnostic services; major restorative services; restorative services other than major restorative services; dental treatment during the Policy Year, the Company will pay the Covered Percentage of the Eligible Dental Expense incurred in connection with covered dental treatment based on the Clinic Fee Schedule of the Howard University College of Dentistry Department of Clinical Dentistry. The Eligible Dental Expense must be incurred while the Covered Person is insured for these benefits.

DEFINITIONS
Eligible Dental Expense" means charges by a dentist, other Doctor or dental hygienist acting within the scope of such person's license that is:
(a) a dental procedure listed in the Clinical Fee Schedule of the Howard University College of Dentistry Department of Clinical Dentistry;
(b) customarily used for treatment of the dental condition; and
(c) done according to accepted standards of dental practice.

BENEFITS
The benefit will be equal to the amount determined by multiplying the fee shown in the Clinic Fee Schedule of the Howard University College of Dentistry Department of Clinical Dentistry by the Covered Percentage shown in the Schedule of Benefits.

The Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE

CODE	DESCRIPTION	FEE
D0120	Periodic Oral Evaluation	$30.00
D0140	Limited Oral Evaluation - Problem Focused	$40.00
D0145	Oral Evaluation - Under 3 Years of Age	$40.00
D0150	Comprehensive Oral Evaluation - New Patient	$40.00
D0160	Detailed & Extensive Oral Evaluation - Problem Focus Report	$35.00
D0170	Re-Evaluation - Limited - Prob focused	$20.00
D0180	Comprehensive Perio Evaluation	$40.00
D0190	Screening of a patient	$40.00
D0191	Assessment of a Patient	$0.00
D0210	Intraoral Radiographs - Complete Series	$75.00
D0220	Intraoral Radiograph - Periapical 1st Film	$15.00
D0230	Intraoral Radiograph - Periapical Additional Film	$6.00
D0240	Intraoral Radiographs - Occlusal Film	$11.00
D0250	Extraoral Radiograph - First Film	$13.00
D0260	Extraoral Radiograph - Each Additional Film	$6.00
D0270	Bitewing - Single Film	$15.00
D0272	Bitewings - 2 Films	$12.00
D0274	Bitewings - 4 Films	$24.00
D0277	Vertical Bitewings - 7-8 Films	$60.00
D0290	Posterior-Anterior or Lateral Skull Survey Film	$65.00
D0310	Sialography	$90.00
D0322	Tomographic Survey	$190.00
D0330	Panoramic Film	$60.00
D0340	Cephalometric Film	$50.00
D0350	Oral/Facial Photographic Images	$25.00
D0415	Bacterial Studies for Pathologic Agents	$20.00
D0425	Caries Susceptibility Tests	$25.00
D0431	Pre-Diagnostic Mucosal Test	$65.00
D0460	Pulp Vitality Tests	$20.00
D0470	Diagnostic Casts	$25.00
D0484	Consultation on Slides Prepared Elsewhere	$10.00
D0485	Consultation Including Preparation of Slides	$10.00
D0502	Other Oral Pathology Procedure (By Report)	$40.00
D1110	Prophy - Adult	$57.00
D1120	Prophy - Child	$35.00
D1203	Fluoride Not Including Prophy - Child	$20.00
D1204	Fluoride Not Including Prophy - Adult	$15.00
D1206	Topical Fluoride Varnish; Therapeutic Application	$20.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D1208	Topical Application of Fluoride	$15.00
D1310	Nutritional Counseling	$40.00
D1320	Tobacco Counseling	$45.00
D1330	Oral Hygiene Instructions	$10.00
D1351	Sealant - per tooth	$20.00
D1352	Preventive Resin Restoration	$45.00
D1510	Space Maintainer Fixed - Unilateral	$200.00
D1515	Space Maintainer Fixed - Bilateral	$250.00
D1520	Space Maintainer - Removable - Unilateral	$245.00
D1525	Space Maintainer - Removable - Bilateral	$250.00
D1550	Space Maintainer - Recementation	$25.00
D1555	Removal of Fixed Space Maintainer	$25.00
D2140	Amalgam - 1 Surface	$60.00
D2150	Amalgam - 2 Surfaces	$80.00
D2160	Amalgam - 3 Surfaces	$90.00
D2161	Amalgam - 4+ Surfaces	$95.00
D2330	Resin/Composite - 1 Surface - Anterior	$90.00
D2331	Resin/Composite - 2 Surfaces - Anterior	$105.00
D2332	Resin/Composite - 3 Surfaces - Anterior	$115.00
D2335	Resin/Composite - 4+ Surfaces - Anterior	$125.00
D2390	Resin-based Composite Crown - Anterior	$155.00
D2391	Resin/Composite - 1 Surface - Posterior	$90.00
D2392	Resin/Composite - 2 Surface - Posterior	$105.00
D2393	Resin/Composite 3 Surface - Posterior	$130.00
D2394	Resin/Composite 4 + Surface - Posterior	$155.00
D2510	Inlay - Metallic - 1 Surface	$210.00
D2520	Inlay - Metallic - 2 Surfaces	$225.00
D2530	Inlay - Metallic - 3 or More Surfaces	$245.00
D2542	Onlay - Metallic - 2 Surfaces	$260.00
D2543	Onlay - Metallic - 3 Surfaces	$300.00
D2544	Onlay - Metallic - 4 or More Surfaces	$310.00
D2610	Inlay - Porcelain/Ceramic - 1 Surface	$200.00
D2620	Inlay - Porcelain/Ceramic - 2 Surfaces	$235.00
D2630	Inlay - Porcelain/Ceramic - 3+ Surfaces	$280.00
D2642	Onlay - Porcelain/Ceramic - 2 Surfaces	$295.00
D2643	Onlay - Porcelain Ceramic - 3 Surfaces	$310.00
D2644	Onlay - Porcelain/Ceramic - 4+ Surfaces	$325.00
D2650	Inlay - Resin - 1 Surface	$195.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D2651	Inlay - Resin - 2 Surfaces	$210.00
D2652	Inlay - Resin - 3+ Surfaces	$225.00
D2662	Onlay - Resin - 2 Surfaces	$250.00
D2663	Onlay - Resin - 3 Surfaces	$275.00
D2664	Onlay - Resin - 4+ Surfaces	$300.00
D2710	Crown Resin (Indirect)	$90.00
D2720	Crown Resin - With High Noble Metal	$450.00
D2721	Crown Resin - With Predominantly Base Metal	$300.00
D2722	Crown Resin - With Noble Metal	$300.00
D2740	Crown Porcelain/Ceramic Substrate	$390.00
D2750	Crown PFM High Noble Metal	$400.00
D2751	Crown PFM Predominently Base Metal	$300.00
D2752	Crown PFM With Noble Metal	$325.00
D2780	Crown 3/4 Cast High Noble Metal	$400.00
D2783	Crown 3/4 Porcelain/Ceramic	$500.00
D2790	Crown Full Cast High Noble Metal	$375.00
D2791	Crown Full Cast Predominently Base Metal	$350.00
D2792	Crown Full Cast Noble Metal	$350.00
D2794	Crown - Titanium	$700.00
D2799	Provisional Crown	$100.00
D2910	Recement Inlay/Onlay Part Coverage	$50.00
D2915	Recement Cast Prefabricated Post and Core	$50.00
D2920	Recement Crown	$50.00
D2930	Prefabricated Stainless Steel crown - Primary Tooth	$150.00
D2931	Prefabricated Stainless Steel Crown - Perm. Tooth	$175.00
D2932	Prefabricated Resin Crown	$125.00
D2933	Prefabricated Stainless Steel Crown - Resin Window	$150.00
D2940	Protective Restoration	$50.00
D2950	Core Buildup - Including Pins	$75.00
D2951	Pin Retention - Per Tooth (Additional to Restorative Charge)	$15.00
D2952	Cast Post and Core (In Addition to Crown)	$175.00
D2953	Addional Cast Post - Same Tooth	$40.00
D2954	Prefab Post and Core w/crown	$135.00
D2955	Post Removal	$65.00
D2960	Labial Veneer (Resin Laminate) - Chairside	$100.00
D2961	Labial Veneer (Resin Laminate) - Laboratory Processed	$135.00
D2962	Labial Veneer (Porcelain Laminate) - Laboratory Processed	$400.00
D2980	Crown Repair (By Report)	$60.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D3110	Pulp Cap - Direct	$25.00
D3120	Pulp cap - indirect	$25.00
D3220	Theraputic Pulpotomy	$50.00
D3221	Pulpal Debridement - Primary/Permanent	$60.00
D3222	Pulpotomy-Partial	$70.00
D3230	Endo Therapy - Anterior Primary tooth	$100.00
D3240	Endo Therapy Posterior Primary Tooth	$125.00
D3310	Endo Therapy - Anterior Permanent Tooth	$325.00
D3320	Endo Therapy - Bicuspid Permanent Tooth	$425.00
D3330	Endo Therapy - Molar Permanent Tooth	$525.00
D3333	Internal Root Repair of Perforation Defects	$75.00
D3346	Retreatment of Previous RCT - Anterior	$425.00
D3347	Retreatment of Previous RCT - Bicuspid	$525.00
D3348	Retreatment of Previous RCT - Molar	$575.00
D3351	Apexification/Recalcification - Initial Visit	$150.00
D3352	Apexification/Recalification - Interim Medication	$ 50.00
D3354	Pulpal Regeneration (necrotic pulp)	$70.00
D3410	Apicoectomy/Periradicular Surgery - Anterior	$390.00
D3421	Apicoectomy/Periradicular Surgery - Bicuspid - First Root	$440.00
D3425	Apicoectomy/Periradicular Surgery - Molar - First Root	$560.00
D3426	Apicoectomy/Periradicular Surgery - Addional Roots	$115.00
D3430	Retrograde Filling - Per Root	$140.00
D3450	Root Amputation - Per Root	$300.00
D3460	Endodontic Endosseous Implant	$390.00
D3470	Intentional Reimplantation	$390.00
D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$65.00
D3920	Hemisection - Including Root Removal	$150.00
D3950	Canal Preparation and Fitting of Preformed Dowel or Post	$85.00
D4210	Gingivectomy/Gingivoplasty - 4 or More Contiguous Teeth	$195.00
D4211	Gingivectomy/Gingivoplasty - 1-3 Contiguous Teeth	$75.00
D4230	Anatomical Crown Exposure - Over 4 Contiguous Teeth per Quad	$275.00
D4231	Anatomical Crown Exposure - 1 to 3 Teeth Per Quadrant	$200.00
D4240	Gingival Flap - 4 or More Teeth Per Quadrant	$195.00
D4241	Gingival Flap - 1-3 Teeth Per Quadrant	$150.00
D4245	Apically Positioned Flap	$290.00
D4249	Clinical Crown Lengthening - Hard Tissue	$280.00
D4260	Osseous Surgery - 4+ Teeth Per Quadrant	$295.00
D4261	Osseous Surgery - 1-3 Teeth Per Quadrant	$235.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D4263	Bone Replacement Graft - First Site Per Quadrant	$200.00
D4264	Bone Replacement Graft - Additional Site Per Quadrant	$125.00
D4265	Biologic Materials To Aid in Tissue Regeneration	$150.00
D4266	Guided Tissue Regeneration - Resorbable Barrier	$280.00
D4267	Guided Tissue Regeneration - Nonresorbable Barrier	$350.00
D4268	Surgical Revision Procedure - Per Tooth	$90.00
D4270	Pedicle Soft Tissue Graft	$225.00
D4271	Free Soft Tissue Graft incl. Donor Site Surg	$250.00
D4273	Subepithelial Connective Tissue Graft	$300.00
D4274	Distal or Proximal Wedge	$195.00
D4275	Soft Tissue Allograft	$250.00
D4276	Combined Connective Tissue Double Pedicle Graft	$450.00
D4320	Provisional Splinting - Intracoronal	$175.00
D4321	Provisional Splinting - Extracoronal	$90.00
D4341	Periodontal Scaling & Root Planing - 4 or More Teeth/Quad	$50.00
D4342	Scaling/Rt planing 1-3 teeth	$45.00
D4355	Full mouth debridement	$60.00
D4381	Localized Delivery of Antimicrobial Agent - 1st Site	$95.00
D4910	Periodontal Maintenance	$60.00
D5110	Complete Denture - Maxillary	$450.00
D5120	Complete Denture - Mandibular	$500.00
D5130	Immediate Denture - Maxillary	$550.00
D5140	Immediate Denture - Mandibular	$540.00
D5150	Duplicate Complete Denture Maxillary	$250.00
D5160	Duplicate Complete Denture Mandibular	$250.00
D5211	Maxillary Partial Denture - Resin Base	$225.00
D5212	Mandibular Partial Denture - Resin Base	$225.00
D5213	Maxillary Partial Denture - Cast Metal Frame	$500.00
D5214	Mandibular Partial Denture - Cast Metal Frame	$500.00
D5225	Maxillary Partial Denture - Flexible Base	$400.00
D5226	Mandibular Partial Denture - Flexible Base	$490.00
D5410	Adjust Complete Denture - Maxillary	$20.00
D5411	Adjust Complete Denture - Mandibular	$20.00
D5421	Adjust Partial Denture - Maxillary	$20.00
D5422	Adjust Partial Denture - Mandibular	$20.00
D5510	Repair Broken Complete Denture Base	$50.00
D5520	Replace Missing or Broken Teeth - Complete Denture Per Tooth	$75.00
D5610	Repair Resin Denture Base - Partial Denture	$50.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D5620	Repair Cast Framework - Partial Denture	$55.00
D5630	Repair or Replace Broken Clasp - Partial Denture	$75.00
D5640	Replace Broken tooth - Partial Denture Per Tooth	$50.00
D5650	Add Tooth to Existing Partial Denture	$50.00
D5660	Add Clasp to Existing Partial Denture	$75.00
D5670	Replace All Teeth on Cast Metal Framework - RPD (Max)	$175.00
D5671	Replace All Teeth on Cast Metal Framework - RPD (Mand)	$175.00
D5710	Rebase Complete Maxillary Denture	$150.00
D5711	Rebase Complete Mandibular Denture	$150.00
D5720	Rebase Maxillary Partial Denture	$100.00
D5721	Rebase Mandibular Partial Denture	$100.00
D5730	Reline Complete Maxillary Denture - Chairside	$75.00
D5731	Reline Complete Mandibular Denture - Chairside	$75.00
D5740	Reline Partial Maxillary Denture - Chairside	$60.00
D5741	Reline Partial Mandibular Denture - Chairside	$60.00
D5750	Reline Complete Maxillary Denture - Laboratory	$100.00
D5751	Reline Complete Mandibular Denture - Laboratory	$100.00
D5760	Reline Partial Maxillary Denture - Laboratory	$100.00
D5761	Reline Partial Mandibular Denture - Laboratory	$90.00
D5810	Interim Complete Denture - Maxillary	$300.00
D5811	Interim Complete Denture - Mandibular	$200.00
D5820	Interim Partial Denture - Maxillary	$150.00
D5821	Interim Partial Denture - Mandibular	$150.00
D5850	Tissue Conditioning - Maxillary	$50.00
D5851	Tissue Conditioning - Mandibular	$50.00
D5860	Overdenture - Complete (By Report)	$525.00
D5861	Overdenture - Partial (By Report)	$500.00
D5862	Precision Attachment (By Report)	$165.00
D5867	Replace of Part of Precision Attachment Replace	$90.00
D5875	Modification of Removable Prosthesis After Implant Surgery	$90.00
D5982	Surgical Stent	$150.00
D5986	Fluoride Gel Carrier	$75.00
D6010	Surgical Placement of Implant Body - Endosteal Implant	$740.00
D6040	Surgical Placement - Eposteal Implant	$740.00
D6050	Surgical Placemnt - Transosteal Implant	$2,990.00
D6053	Implant Supported Rem Denture for Completely Edent Arch	$4,790.00
D6054	Implant Supported Rem Denture for Partially Edent Arch	$3,190.00
D6055	Dental Implant Supported Connecting Bar	$2,390.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D6056	Prefabricated Implant Abutment	$590.00
D6057	Custom Implant Abutment	$640.00
D6058	Implant Abutment Supported Porcelain/Ceramic Crown	$490.00
D6059	Implant Abutment Supported PFM Crown (High Noble Metal)	$490.00
D6061	Implant Abutment Supported PFM Crown (Noble Metal)	$490.00
D6062	Implant Abutment Supported Metal Crown (High Noble Metal)	$490.00
D6063	Implant Abutment Supported Metal Crown (Base Metal)	$490.00
D6064	Implant Abutment Supported Metal Crown (Noble Metal)	$490.00
D6065	Implant Supported Porcelain/Ceramic Crown	$490.00
D6066	Implant Supported Porcelain Fused to Metal Crown	$490.00
D6067	Implant Supported Metal Crown	$490.00
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	$550.00
D6069	Abutment Supported Retainer for PFM FPD (High Noble Metal)	$540.00
D6071	Implant Abutment Supported Retainer for PFM FPD (Base Metal)	$540.00
D6071	Implant Abutment Supported Retainer for PFM FPD (Base Metal)	$550.00
D6072	Implant Abutment Supported Retainer Metal FPD (High Noble)	$540.00
D6073	Implant Abutment Supported Retainer Metal FPD (Base Metal)	$540.00
D6074	Implant Abutment Supported Retainer Metal FPD (Noble Metal)	$540.00
D6075	Implant Supported Retainer for Ceramic FPD	$540.00
D6077	Implant Supported Retainer for Cast Metal FPD	$540.00
D6078	Implant Supported Fixed Denture for Completely Edent Arch	$7,990.00
D6079	Implant Supported Fixed Denture for Partially Edent Arch	$3,990.00
D6080	Implant Maintenance Procedures	$115.00
D6090	Repair Implant Supported Prosthesis (By Report)	$290.00
D6095	Repair Implant Abutment (By Report)	$390.00
D6100	Implant Removal	$400.00
D6190	Radographic/Surgical Implant Index (By Report)	$165.00
D6210	Pontic - Cast High Noble Metal	$590.00
D6211	Pontic - Cast Predominantly Base Metal	$590.00
D6212	Pontic - Cast Noble Metal	$590.00
D6214	Pontic - Titanium	$690.00
D6240	Pontic - Porcelain Fused to Metal - High Noble	$565.00
D6241	Pontic - Porcelain Fused to Metal - Base Metal	$565.00
D6242	Pontic - Porcelain Fused to Metal - Noble Metal	$565.00
D6245	Pontic - Porcelain/Ceramic	$565.00
D6250	Pontic -Resin with High Noble Metal	$490.00
D6251	Pontic - Resin with Predominantly Base Metal	$490.00
D6252	Pontic - resin with noble metal	$490.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D6540	Onlay Metallic	$290.00
D6545	Retainer - Metal for Resin Bonded Fixed Prosthesis	$390.00
D6548	Retainer - Porcelain/Cer. for Resin Bonded Fixed Prosthesis	$340.00
D6600	Retainer - Inlay - Porcelain/Ceramic - 2 surfaces	$390.00
D6601	Retainer - Inlay - Porcelain/Ceramic - 3+ surfaces	$465.00
D6602	Retainer - Inlay - High Noble Metal - 2 surfaces	$340.00
D6603	Retainer - Inlay - High Noble Metal - 3+ surfaces	$385.00
D6604	Retainer - Inlay - Predominantly Base Metal - 2 surfaces	$315.00
D6605	Retainer - Inlay - Predominantly Base Metal - 3+ surfaces	$340.00
D6606	Retainer - Inlay - Cast Noble Metal - 2 surfaces	$340.00
D6607	Retainer - Inlay - Cast Noble Metal - 3+ surfaces	$385.00
D6608	Retainer - Onlay - Porcelain/Ceramic - 2 surfaces	$390.00
D6609	Retainer - Onlay - Porcelain/Ceramic - 3+ surfaces	$440.00
D6610	Retainer - Onlay - High Noble Metal - 2 surfaces	$390.00
D6611	Retainer - Onlay - High Noble Metal - 3+ surfaces	$465.00
D6612	Retainer - Onlay - Predominantly Base Metal - 2 surfaces	$340.00
D6613	Retainer - Onlay - Predominantly Base Metal - 3+ surfaces	$365.00
D6614	Retainer - Onlay - Cast Noble Metal - 2 surfaces	$390.00
D6615	Retainer - Onlay - Cast Noble Metal - 3+ surfaces	$465.00
D6624	Retainer - Inlay - Titanium	$440.00
D6634	Retainer - Onlay - Titanium	$490.00
D6710	Crown - indirect resin based composite	$490.00
D6720	Retainer - Crown - Resin With High Noble Metal	$490.00
D6721	Retainer - Crown - Resin with Predominantly Base Metal	$490.00
D6722	Retainer - Crown - Resin With Noble Metal	$490.00
D6740	Retainer - Crown - Porcelain/Ceramic	$490.00
D6750	Retainer - Crown - Porcelain Fused to Metal - High Noble	$565.00
D6751	Retainer - Crown - Porcelain Fused to Metal - Base Metal	$565.00
D6752	Retainer - Crown - Porcelain Fused to Metal - Noble Metal	$565.00
D6780	Retainer - 3/4 Crown Cast High Noble Metal	$250.00
D6781	Retainer - 3/4 Crown Cast Predominantly Base Metal	$390.00
D6782	Retainer - 3/4 Crown Cast Noble Metal	$390.00
D6783	Retainer - 3/4 Crown Porcelain/Ceramic	$440.00
D6790	Retainer - Crown Cast High Noble Metal	$590.00
D6791	Retainer - Crown Cast Predominantly Base Metal	$590.00
D6792	Retainer - Crown Cast Noble Metal	$590.00
D6794	Retainer - Crown - Titanium	$690.00
D6920	Connector Bar	$405.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D6930	Recement Fixed Partial Denture	$60.00
D6940	Stress Breaker	$65.00
D6950	Precision Attachment	$55.00
D6970	Cast Post & Core - In Addition to FPD	$190.00
D6971	Cast post - part of FPD ret	$140.00
D6972	Prefabricated Post & Core - in Addition to FPD	$85.00
D6973	Core Build Up For Retainer Including Pins	$90.00
D6975	Coping - Metal	$300.00
D6980	Fixed Partial Denture Repair (By Report)	$55.00
D7111	Coronal Remnants - Deciduous Tooth	$30.00
D7140	Extraction - Erupted Tooth or Exposed Root	$65.00
D7141	Extraction of adjacent tooth	$55.00
D7210	Surgical Removal of Erupted Tooth	$110.00
D7220	Removal of Impacted Tooth - Soft Tissue	$125.00
D7230	Removal of Impacted Tooth - Partially Bony	$150.00
D7240	Removal of Impacted Tooth - Completely Bony	$210.00
D7241	Removal of Impacted Tooth - Completely Bony-Complicated	$245.00
D7250	Removal of Residual Tooth Roots	$80.00
D7260	Oroantral Fistula Closure	$340.00
D7261	Primary Closure of a Sinus Perforation	$440.00
D7270	Tooth Reimplantation and/or Stabilization of Evulsed Tooth	$300.00
D7272	Tooth Transplantation	$440.00
D7280	Surgical Access of an Unerupted Tooth	$275.00
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$190.00
D7285	Biopsy of Oral Tissue - Hard	$240.00
D7286	Biopsy of Oral Tissue - Soft	$175.00
D7288	Brush Biopsy - Transepithelial Sample Collection	$95.00
D7310	Alveoloplasty With Extractions - 4+ Teeth	$90.00
D7311	Alveoloplasty with Extractions - 1 - 3 Teeth	$75.00
D7320	Alveoloplasty Not With Extractions - 4+ Teeth	$240.00
D7321	Alveoloplasty Not With Extractions - 1 - 3 Teeth	$155.00
D7340	Vestibuloplasty - second epith	$240.00
D7410	Excision - Benign Soft Tissue Lesion < 1.25cm	$105.00
D7411	Excision - Benign Soft Tissue Lesion > 1.25cm	$135.00
D7412	Excision - Benign Soft Tissue Lesion - Complicated	$175.00
D7413	Excision - Malignant Soft Tissue Lesion < 1.25cm	$100.00
D7414	Excision - Malignant Soft Tissue Lesion > 1.25cm	$240.00
D7415	Excision - Malignant Soft Tissue Lesion - Complicated	$265.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D7450	Removal of Benign Odonogenic Cyst/Tumor < 1.25cm	$165.00
D7451	Removal of Benign Odonogenic Cyst/Tumor > 1.25cm	$245.00
D7460	Removal of Benign Nonodontogenic Cyst < 1.25cm	$135.00
D7461	Removal of Benign Nonodontogenic Cyst > 1.25cm	$190.00
D7471	Removal of Lateral Exostosis	$180.00
D7472	Removal of Torus Palatinus	$340.00
D7473	Removal of Torus Mandibularis	$290.00
D7485	Surgical Reduction of Osseous Tuberosity	$240.00
D7510	Incision/Dainage of Abscess - Intraoral Soft Tissue	$85.00
D7520	Incision/Dainage of Abscess - Extraoral Soft Tissue	$135.00
D7880	Occlusal Orthotic Device (By Report)	$365.00
D7899	Unspecified TMD Therapy (By Report)	$290.00
D7910	Suture of Recent Small Wounds up to 5cm	$190.00
D7911	Complicated Suture - up to 5cm	$240.00
D7912	Complicated Suture - > 5cm	$340.00
D7950	Osseous- Osteoperiostial or Cartilage Graft-Mand or Max	$740.00
D7953	Bone Replacement Graft for Ridge Preservation - per site	$740.00
D7960	Frenulectomy (Frenectomy or Frenotomy) - Separate Procedure	$195.00
D7970	Excision of Hyperplastic Tissue - Per Arch	$240.00
D7972	Surgical Reduction of Fibrous Tuberosity	$150.00
D7980	Sialolithotomy	$440.00
D7999	Unspecified Oral Surgery Procedure (By Report)	$840.00
D8670	Periodic ortho treatment visit	$100.00
D9110	Palliative Treatment of Dental Pain - Minor Procedure	$90.00
D9230	Analgesia - Anxiolysis - Inhalation of Nitrous Oxide	$70.00
D9241	Intravenous Consious Sedation/Analgesia - 1st 30 min	$115.00
D9242	Intrav sedate/analg-add 15 min	$40.00
D9248	Non-intravenous Conscious Sedation	$115.00
D9310	Consultation	$65.00
D9420	Hospital Call	$25.00
D9430	Office Visit for Observation - No Other Services Performed	$10.00
D9440	Office Visit - After Regularly Scheduled Hours	$40.00
D9610	Therapeutic Parenteral Drug - Single Administration	$40.00
D9910	Application of Desensitizing Medicament	$25.00
D9912	Duplication of X-Rays	$50.00
D9920	Behavior Management (By Report)	$50.00
D9930	Treatment of Complications (Post-Surgical) - Unusual Circum.	$115.00
D9940	Occlusal Guard (By Report)	$300.00

DENTAL TREATMENT EXPENSE (Available at the Howard University Outpatient Clinic at the College of Dentistry Only) (continued)

CLINIC FEE SCHEDULE (continued)

CODE	DESCRIPTION	FEE
D9941	Fabrication of Athletic Mouthguard	$125.00
D9950	Occlusion Analysis - Mounted Case	$50.00
D9951	Occlusal Adjustment - Limited	$65.00
D9952	Occlusal Adjustment - Complete	$150.00
D9970	Enamel Microabrasion	$145.00
D9972	External Bleaching - First Arch	$160.00
D9973	External Bleaching - Per Tooth	$70.00
D9974	Internal Bleaching - Per Tooth	$85.00
D9999	Unspecified Adjunctive Procedure (By Report)	$90.00

DENTAL TREATMENT EXPENSE FOR IMPACTED WISDOM TEETH

If a Covered Person incurs Eligible Dental Expenses for services of a legally qualified dentist or dental surgeon for removal of one or more impacted wisdom teeth, the Company will pay the Eligible Dental Expenses incurred as shown in the Schedule of Benefits. The Eligible Dental Expenses must be incurred while the Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

SECOND SURGICAL OPINION EXPENSE

To the extent that this Policy provides benefits for surgery, this Policy shall provide benefits to a Covered Person for Eligible Expenses incurred in excess of the Co-pay, if applicable, for a second opinion consultation by a specialist on the need for non-emergency surgery which has been recommended by the Covered Person's Doctor. The specialist must be board certified in the medical field relating to the surgical procedure being proposed. Benefits will also be provided for any Eligible Expenses incurred for required X-rays and diagnostic tests done in connection with that consultation. The Company will pay the Covered Percentage of the Eligible Expense incurred.

The Covered Percentage is shown in the Schedule of Benefits. The Company must receive a written report on the second opinion consultation.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

PRESCRIBED MEDICINES EXPENSE

If, by reason of Injury or Sickness, a Covered Person requires medicines, the Company will pay the Covered Percentage of the Eligible Expense incurred by the Covered Person for such medicines that is in excess of the Co-pay Amount per prescription. The medicines must be prescribed by the attending Doctor. The prescriptions must be filled at a Script Care participating pharmacy. This coverage shall include hormone replacement therapy that is prescribed or ordered for the treating of symptoms and conditions of menopause.

Eligible Expenses do not include drugs labeled "Caution - limited by Federal Law to investigational use", or any experimental drugs, even though a charge is made, except that charges for cancer treatment drugs are covered prescription drug Expense on the basis that such drugs are recognized to be effective for such treatment in an established reference compendia.

Prescription Drugs and Devices for Birth Control
Benefits are payable for Eligible Expenses incurred for prescription contraceptive drugs and devices that are approved by the federal Food and Drug Administration (FDA). The Company will pay benefits for the Eligible Expense incurred as shown in the Schedule of Benefits.

For purposes of this coverage, prescription medicine means a drug or medicine which may be obtained only on a Doctor’s written prescription.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

HOME HEALTH CARE EXPENSE

When, by reason of Injury or Sickness, a Covered Person incurs Eligible Expenses for Covered Home Health Care Services, the Company will pay the Covered Percentage of the Eligible Expense based on the amount of the Eligible Expenses incurred for not more than the Maximum Number of Visits per Policy Year shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

Covered Home Health Care Services: Covered Home Health Care Services are the services and supplies shown in the List of Covered Home Health Care Services below, to the extent that the charges are Reasonable and Customary, subject to the following conditions:

(a) the service must be Medically Necessary.
(b) the service must be furnished by, or under arrangements made by, a licensed Home Health Agency.
(c) the service must be covered under a Home Health Care Plan. This plan must be established pursuant to the written order of a Doctor and the Doctor must renew that plan every 60 days.
(d) except as specifically provided in the list of Covered Home Care Services, the service must be delivered in the patient's place of residence on a part-time, intermittent, Visit basis while the patient is confined as a result of Injury or Sickness.

LIST OF COVERED HOME HEALTH CARE SERVICES

(1) Nursing care furnished by:
  (a) a Registered Nurse (R.N.)
  (b) a Licensed Practical Nurse (L.P.N.)
  (c) a Licensed Visiting Nurse
  (d) a home health aide

  But, this service does not qualify as a Covered Home Health Care Service if the nurse or home health aide resides in the Covered Person's home or is an Immediate Family Member of the Covered Person.

(2) Physical, occupational, speech or respiratory therapy.
(3) Services of a medical social worker.
(4) Nutrition counseling.
(5) Medical supplies, drugs and medicines, and laboratory services. But, these items are covered only to the extent they would be covered if the patient was confined to a Hospital.

EXCLUSIONS FOR HOME HEALTH CARE SERVICES

(a) Services or supplies for personal comfort or convenience, including homemaker services;
(b) Services related to well-baby care; and
(c) Food services or meals other than dietary counseling excluding tube feedings.

DEFINITIONS:

"Home Health Agency" means:

(a) an agency licensed as a home health agency by the state in which home health care services are provided; or
(b) an agency certified as such under Medicare; or
(c) an agency approved as such by the Company.

"Visit" means a maximum of four (4) continuous hours of home health service.

HOME HEALTH CARE EXPENSE (continued)

"Home Health Care" means health services and supplies provided to a Covered Person on a part-time, intermittent, Visit basis. Such services and supplies must be provided in such person's place of residence while the person is confined as a result of Injury or Sickness. Also, a Doctor must certify that the use of such services and supplies is to treat a condition as an alternative to confinement in a Hospital or extended care facility (ECF).

"Home Health Care Plan" means a plan of care established and approved in writing by a Doctor**.**

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all terms of this Policy.

HOSPICE CARE EXPENSE

When, by reason of Injury or Sickness, a Doctor certifies that a Covered Person is terminally ill and Eligible Hospice Care Expenses are incurred, the Company will pay the Covered Percentage of the Eligible Expense incurred on the same basis as any other Sickness. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

"Hospice" means a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent hospice administration and it helps the patient cope with physical, psychological, spiritual, social and economic stresses. The hospice administration must meet the standards of the National Hospice Organization and any licensing requirement.

"Hospice Benefit Period" means a period that begins on the date the attending Doctor certifies that the Covered Person is a terminally ill patient who has less than 6 months to live. It ends after 6 months (or such later period for which treatment is certified) or on the death of the patient, if sooner.

"Eligible Hospice Care Expenses" are the Reasonable and Customary charges made by a Hospice for the following services or supplies:

(a) charges for inpatient care;
(b) charges for drugs and medicines;
(c) charges for part-time nursing by an RN, LPN or LVN;
(d) charges for physical and respiratory therapy in the home;
(e) charges for the use of medical equipment;
(f) charges for visits by licensed or trained social workers, psychologists or counselors;
(g) charges for bereavement counseling of the Covered Person's Immediate Family Members prior to, and within 3 months after, the Covered Person's death.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

MATERNITY TESTING EXPENSE

Benefits are payable for Eligible Expenses incurred by a Covered Person for routine maternity tests and screening exams. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits. The Company will pay the benefit for the Eligible Expense on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

Benefits will be paid for Eligible Expenses incurred for the following tests:

(a) pregnancy tests;
(b) CBC;
(c) Hepatitis B Surface Antigen;
(d) Rubella Screen;
(e) Syphilis Screen;
(f) Chlamydia;
(g) HIV;
(h) Gonorrhea;
(i) Toxoplasmosis;
(j) Blood Typing ABO;
(k) RH Blood Antibody Screen;
(l) Urinalysis;
(m) Urine Bacterial Culture;
(n) Microbial Nucleic Acid Probe;
(o) AFP Blood Screening;
(p) Pap Smear; and
(q) Glucose challenge Test (at 24 - 28 weeks gestation)

One ultrasound test may be administered per pregnancy without any additional diagnosis. Eligible Expenses for subsequent ultrasound tests may be payable if such additional tests are determined to be Medically Necessary. In addition, for a female Covered Person over 35 years of age, charges for the following tests may be considered Eligible Expenses:

(a) amniocentesis/AFP Screening;
(b) chromosome testing; and
(c) fetal stress/non-stress tests.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

MANDATED COVERAGES

ORAL ANTICANCER MEDICATION COVERAGE

Benefits will be payable 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. A medication provided under this provision will be prescribed only upon finding that it is Medically Necessary by the treating Doctor for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the Covered Person, Doctor or other health care provider. The Covered Person has the option of having such medication dispensed at any appropriately licensed pharmacy. The Eligible Expenses must be incurred while a Covered Person is insured for these benefits.

The Company will pay benefits on the same basis as for any other Sickness according to the limits and maximums shown in the Schedule of Benefits for the following:

For purposes of this coverage, prescription medicine means a drug or medicine which may be obtained only on a Doctor's written prescription.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

SUBSTANCE ABUSE AND MENTAL ILLNESS EXPENSE

When a Covered Person requires treatment for alcoholism or alcohol abuse, substance abuse or substance dependency, or a mental illness, the Company will pay benefits for the inpatient and outpatient Eligible Expenses incurred at a Hospital, Residential Treatment Facility, Intermediate Care Facility or Outpatient Treatment Facility on the same basis as any other Sickness. The Company will not pay more than the Aggregate Maximum Amount shown in the Schedule of Benefits. The need for treatment must be certified by a Doctor, psychologist, advanced practice registered nurse or social worker and must be a clinically significant disorder as identified in the most recent edition of the International Classification of Diseases of the Diagnostic and Statistical Manual of the American Psychiatric Association.

"Residential Treatment Facility" means a facility which provides 24 hour treatment for people with drug abuse or alcohol abuse on an inpatient basis. It must provide at least the following: room and board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, family and group counseling; and educational and support services. The Company will recognize a Residential Treatment Facility if it is accredited for its stated purpose by the Joint Commission, and carries out its stated purpose in compliance with all relevant state and local laws.

“Intermediate Care Facility” means a facility which provides for the use, in a full 24-hour residential therapy setting, or in a partial, less than 24-hour, residential therapy setting, any of the following therapeutic techniques, as identified in a treatment for individuals physiologically or psychologically dependent upon or abusing alcohol or drugs:

(a) chemotherapy;
(b) counseling;
(c) detoxification services;
(d) other ancillary services, such as medical testing, diagnostic evaluation and referral to other services identified in the treatment plan.

OUTPATIENT TREATMENT

“Outpatient Treatment Facility” means a clinic, counseling center, or other similar location that is certified by the jurisdiction in which it is located as a qualified provider of outpatient services for the treatment of drug abuse, alcohol abuse, or mental illness.

"Covered Outpatient Services for the treatment of Substance Abuse and Mental Illness” means the services furnished by the following:

(a) a comprehensive health care service organization;
(b) a Hospital;
(c) by a facility approved by the State Department of Mental Health which is:
- a community mental health center; or
- any other mental health clinic; or
- an independent clinical social worker; or
- a clinical specialist in psychiatric and mental health nursing; or

(d) the office of a Doctor, psychologist or social worker.

“Advanced practice registered nurse” means a person licensed as a registered nurse and certified as an advanced registered nurse pursuant to the District of Columbia Health Occupations Revisions Act of 1985 Amendment Act of 1994 or by the state or territory where the person practices as an advanced practice registered nurse.

MANDATED COVERAGES (continued)

SUBSTANCE ABUSE AND MENTAL ILLNESS EXPENSE (continued)

“Clinically significant” means for the purposes of this coverage, sufficient to substantially impair a person’s judgment, behavior, capacity to recognize, or ability to cope with the ordinary demands of life.

“Detoxification” means the process under which a person who is intoxicated by or dependent on drugs or alcohol or both is assisted through the period of time necessary to eliminate the intoxicating agent or drug from the body while keeping the physiological risk to the patient to a minimum.

Mental Illness means any psychiatric disease identified in the most recent edition of the International Classification of Diseases or of the American Psychiatric Association Diagnosis and Statistical Manual.

"Substance Abuse" means the pathological use of alcohol or other stimulant, depressant or other chemical substance that causes impairment in social or occupational functioning or that produces physiological dependency evidenced by physical tolerance or by physical symptoms when it is withdrawn.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

DIABETES EXPENSE

If, by reason of Sickness, a Covered Person incurs Eligible Expenses for the following equipment and supplies for the treatment of diabetes, the Company will pay the Eligible Expenses incurred. Benefits will be paid for Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. Such equipment and supplies must be recommended in writing or prescribed by a Doctor. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The Eligible Expenses include but are not limited to the following equipment and supplies:

(a) lancets and automatic lancing devices;
(b) glucose test strips;
(c) blood glucose monitors;
(d) blood glucose monitors for the visually impaired;
(e) control solutions used in blood glucose monitors;
(f) diabetes data management systems for management of blood glucose;
(g) urine testing products for glucose and ketones;
(h) oral anti-diabetic agents used to reduce blood sugar levels;
(i) alcohol swabs;
(j) syringes;
(k) injection aids including insulin drawing up devices for the visually impaired;
(l) cartridges for the visually impaired;
(m) disposable insulin cartridges and pen cartridges;
(n) all insulin preparations;
(o) insulin pumps and equipment for the use of the pump including batteries;
(p) insulin infusion devices;
(q) oral agents for treating hypoglycemia such as glucose tablets and gels;
(r) glucagon for injection to increase blood glucose concentration.

Coverage is also provided for Medically Necessary outpatient diabetes self-management training and educational services, including medical nutritional therapy, for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes, if prescribed by a health care professional legally authorized to prescribe such item.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

MANDATED COVERAGES (continued)

MAMMOGRAPHY AND CERVICAL CYTOLOGICAL SCREENING EXPENSE

Benefits are payable for Eligible Expenses incurred for cervical cytology screening and screening mammograms. The Company will pay the Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

Benefits will be paid for Eligible Expenses incurred for the following:

(a) annual cervical cytologic screening for women; and cervical cytologic screening for women upon certification by the attending Doctor that the test is Medically Necessary. This coverage shall include an annual pelvic examination, collection and preparation of a Pap smear, and laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

"Cytologic screening" means a pap test to detect cervical cancer through the simple microscopic examination of cells scraped from the surface of the cervix.

In addition, coverage shall be provided for the following cervical cytology screening services, and such coverage shall be subject to the following and in accordance with the benefits for Preventive Services mandated by the Patient Protection and Affordable Care Act shown in the Schedule of Benefits:

(i) evidence-based items or services for cervical cytology that have in effect a rating of "A" or "B" in the current recommendations of the United States preventive services task force; and

(ii) with respect to a female Covered Person, such additional preventive care and screenings for cervical cytology not described in item (i) above and as provided for in comprehensive guidelines supported by the health resources and services administration.

(b) In the case of mammograms:

(1) a baseline mammogram for women;

(2) an annual screening for women.

"Baseline mammogram" means a screening mammogram that is used as a comparison for future examinations.

"Screening mammogram" means a low-dose x-ray used to visualize the internal structure of the breast.

In addition, coverage shall be provided for the following mammography screening services, and such coverage shall be subject to the following and in accordance with the benefits for Preventive Services shown in the Schedule of Benefits:

(i) evidence-based items or services for mammography that have in effect a rating of "A" or "B" in the current recommendations of the United States preventive services task force; and

(ii) with respect to a female Covered Person, such additional preventive care and screenings for mammography not described in item (i) above and as provided for in comprehensive guidelines supported by the health resources and services administration.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

MANDATED COVERAGES (continued)

COLORECTAL CANCER SCREENING EXPENSE

Benefits are payable for Eligible Expenses incurred by a Covered Person for colorectal cancer screening examinations and laboratory tests in accordance with the most recently published guidelines and recommendations established by the American Cancer Society. Benefits will be paid for Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

MANDATED COVERAGES (continued)

BREAST CANCER TREATMENT

Benefits are payable for Eligible Expenses for a lymph node dissection or a lumpectomy for the treatment of breast cancer or a Mastectomy on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits. In no event will benefits be payable for less than 48 hours following a Mastectomy and 24 hours following a lymph node dissection or a lumpectomy unless the attending Doctor, in consultation with the Covered Person, recommends an earlier discharge.

“Mastectomy” means the removal of all or part of the breast for Medically Necessary reasons as determined by the Doctor.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

RECONSTRUCTIVE BREAST SURGERY

Benefits are payable for Eligible Expenses incurred for breast reconstructive surgery after a Mastectomy. This provision includes coverage for:

(a) all stages of reconstruction of the breast on which the Mastectomy has been performed;
(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(c) prostheses and physical complications at all stages of Mastectomy**,** including lymphedemas.

Benefits provided under this provision will be paid on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

“Mastectomy” means the surgical removal of all or substantially all of a breast as a result of breast cancer.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

PROSTATE CANCER SCREENING

Benefits are payable for Eligible Expenses incurred by a Covered Person for prostate cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society for the ages, family histories, and frequencies referenced in such guidelines. Benefits will be paid for Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This Provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

VOLUNTARY HIV SCREENING TEST EXPENSE

The company will pay the Covered Percentage of the Eligible Expenses incurred by a Covered Person for a voluntary HIV screening test performed while the Covered Person is receiving Emergency Medical Services, other than HIV screening, at a Hospital emergency department, whether or not the HIV screening test is necessary for the treatment of the Emergency Medical Condition which caused the Covered Person to seek Emergency Medical Services. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The benefits covered under this provision shall:

(a) include at least one annual emergency department HIV screening test;
(b) the cost of administering such a test, all laboratory expenses to analyze the test, and the cost of communicating to the Covered Person the results of the test and any applicable follow-up instructions for obtaining health care and supportive services; and
(c) not be subject to any annual or coinsurance Deductible or any Co-pay other than the Co-pay that the Covered Person would have to pay for the applicable Hospital emergency department visit.

"HIV screening test" means the testing for the human immunodeficiency virus or any other identified causative agent of the acquired immune deficiency syndrome by:

(a) conducting a rapid-result test by means of the swabbing of a patient's gums, finger-prick blood test, or other suitable rapid-result test; and
(b) if the result is positive, conducting an additional blood test for submission to a laboratory to confirm the results of the rapid-result test.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

EMERGENCY CARE EXPENSE

If a Covered Person is insured for coverage under the Preferred Provider Plan, and he or she is unable to reasonably reach a Preferred Provider, the Company will pay the Eligible Expenses for the following emergency care services at the Preferred Provider benefit level:

(a) any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital which is necessary to determine whether a medical emergency condition exists;
(b) necessary emergency care services including treatment and stabilization of an Emergency Medical Condition; and
(c) services originating in a Hospital emergency facility following treatment or stabilization of an Emergency Medical Condition.

“Preferred Provider Plan” means a benefit plan through which the Company provides for the payment of a level of coverage that is different from the basic level of coverage provided under this Policy if the Covered Person uses a Preferred Provider.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

CHILD HEALTH SUPERVISION SERVICES (not otherwise covered under Preventive Services)

When the Dependent child of a Covered Student is insured for medical coverages, such Dependent's coverage shall include coverage for Child Health Supervision Services. Benefits are payable for Eligible Expenses incurred in excess of the Deductible Amount, if applicable for Child Health Supervision Services from the moment of birth to age 21 years.

Benefits will be paid for Eligible Expenses incurred for preventive and primary care services, including physical examinations, measurements, sensory screening, neuro-psychiatric evaluation, and development screening, which coverage shall include:

(a) unlimited visits for a Dependent child up to age 12;
(b) three visits per year for a Dependent child age 12 up to 21 years of age.

Preventive and primary care services shall also include, as recommended by the Doctor, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, and other appropriate blood tests, including test to screen for sickle hemoglobinopathy.

"Child Health Supervision Services" means a periodic review of a child's physical and emotional status performed by a Doctor, by a health care professional under the supervision of a Doctor.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of the Policy.

MANDATED COVERAGES (continued)

CLINICAL TRIALS EXPENSE

Benefits are payable for routine patient care costs incurred by a Covered Person as a result of an approved clinical trial for the prevention, early detection, treatment or monitoring of cancer, chronic disease, or life threatening illness. "

Approved clinical trial" means:

(a) a clinical research study or clinical investigation approved or funded in full or in part by one or more of the following:
  (1) The National Institutes of Health (NIH);
  (2) The Centers of Disease Control and Prevention;
  (3) The Agency for Health Care Research and Quality;
  (4) The Centers for Medicare and Medicaid Services;
  (5) a bona fide clinical trial cooperative group, including the National Cancer Institute Clinical Trials Cooperative Group, the National Cancer Institute Community Clinical Oncology Program, the AIDS Clinical Trials Group, and the Community Programs for Clinical Research in AIDS; or
  (6) The Department of Defense, the Department of Veterans Affairs, the Department of Energy, or a qualified nongovernmental research entity to which the National Cancer Institute has awarded a support grant.

(b) a study or investigation approved by the federal Food and Drug Administration ("FDA"), including those conducted under an investigational new drug or device application reviewed by the FDA; or

(c) an investigation or study approved by an Institutional Review Board registered with the Department of Health and Human Services that is associated with an institution that has a federal-wide assurance approved by the Department of Health and Human Services specifying compliance with 45 C.F.R. Part 46.

"Routine patient care costs" means:

(a) items, drugs, and services that are typically provided absent a clinical trial;

(b) items, drugs, and services required solely for the provision of the investigational item or service (such as the administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or prevention of complications; and

(c) items, drugs, and services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

Any clinical trial receiving benefits under this coverage must meet the following requirements:

(a) the subject or purpose of the trial must be the evaluation of an item or service that falls within the covered benefits available under this Policy and not specifically excluded from coverage under this Policy;

(b) the trial must not be designed exclusively to test toxicity or disease pathophysiology;

(c) the trial must have therapeutic intent;

(d) trials of therapeutic interventions must enroll patients with diagnosed disease;

(e) the principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes;

(f) the trial is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use;

(g) the trial does not unjustifiably duplicate existing studies; and

(h) the trial is in compliance with federal regulations relating to the protection of human subject.

MANDATED COVERAGES (continued)

CLINICAL TRIALS EXPENSE (continued)

Charges for services and treatment not covered under this benefit are as follows:

(a) the cost of tests or measurements conducted primarily for the purpose of the clinical trial involved or item, drugs, or services provided solely to satisfy data collection and analysis needs;

(b) items, drugs, or services customarily provided by the research sponsors free of charge for any qualified individual enrolled in the trial.

Eligible Expenses under this coverage will be paid on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

HABILITATIVE SERVICES FOR CHILDREN (not otherwise covered under Preventive Services)

Benefits are payable for Eligible Expenses incurred for habilitative services for a Dependent child under 21 years of age with a congenital or genetic birth defect as long as the following conditions are met:

(a) a Doctor has diagnosed the Dependent child's congenital or genetic birth defect;
(b) the treatment is administered by a licensed speech-language pathologist, licensed audiologist; licensed occupational therapist, licensed physical therapist, Doctor, licensed nurse, licensed optometrist, licensed nutritionist, licensed social worker, or licensed psychologist upon the referral of a Doctor;
(c) the initial or continued treatment must be Medically Necessary and therapeutic and not Experimental or Investigational.

The Eligible Expenses must be incurred while the Dependent child is insured for these benefits. The Company will pay the benefit for the Eligible Expense on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

"Habilitative services" means services, including occupational therapy, physical therapy and speech therapy, for the treatment of a child with a congenital or genetic birth defect to enhance the child's ability to function.

"Congenital or genetic birth defect" means a defect existing at or from birth, including a hereditary defect. The term "congenital or genetic birth defect" includes:
(a) autism or an autism spectrum disorder; and
(b) cerebral palsy.

"Habilitative services" do not include any services that are actually delivered through early intervention or school services.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy or otherwise required by law.

This provision is subject to all of the terms of this Policy.

MANDATED COVERAGES (continued)

NEWBORN HEARING IMPAIRMENT SCREENING (not otherwise covered under Preventive Services)

If a covered newborn Dependent child incurs Eligible Expenses for screening for hearing impairment before discharge from the Hospital or birthing facility, benefits will be payable for such tests that are conducted by an audiologist, otolaryngologist, or other qualified person, in accordance with accepted medical practices.

The screening program shall consist of at least one of the following:
(a) auditory brain stem response;
(b) otoacustic emissions; or
(c) other appropriate nationally recognized, objective physiological screening test.

The Eligible Expenses must be incurred while the Dependent child is insured for these benefits. The Company will pay the Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

REPATRIATION OF REMAINS EXPENSE

Repatriation of Remains Benefit. If a Covered Person suffers loss of life due to Injury or Emergency Sickness while outside a 100 mile radius from his or her current place of primary residence the Company will pay, subject to the limitations set out herein, for the actual expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person.

Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements, including family or friend transportation arrangements in conjunction with a Repatriation of Remains, and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard in advance.

Emergency Sickness - means an illness or disease, diagnosed by a Doctor, which meets all of the following criteria: (1) there is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Covered Person's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while this Policy is in force as to the Covered Person suffering the symptom.

In addition to the Exclusions in the Exclusions and Limitations section of this Policy, Repatriation of Remains benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which the Covered Person is entitled to benefits under any Workers' Compensation Act or similar law.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

MEDICAL EVACUATION EXPENSE

The Company will pay, subject to the limitations set out herein, for Eligible Medical Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Emergency Sickness that warrants his or her Medical Evacuation while he or she is outside a 100 mile radius from his or her current place of primary residence but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all Emergency Sicknesses from the same or related causes.

The Doctor ordering the Medical Evacuation must certify that the severity of the Covered Person's Injury or Emergency Sickness warrants his or her Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements, including family or friend transportation arrangements in conjunction with an Medical Evacuation, and must authorize all expenses in advance for any Medical Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard in advance.

Eligible Medical Evacuation Expense(s) means an expense that: (1) is charged for a Medically Necessary Medical Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Medical Evacuation means: (1) Transportation to the nearest adequate medical facility following the Covered Person's Injury or Emergency Sickness if the Covered Person is outside his or her home country and the Doctor determines that adequate treatment is not available locally; or (2) ambulance service to the nearest airport and air ambulance upon departure; or (3) special air transportation costs for return of the Covered Person to his or her home country if the Doctor recommends in writing that the condition requires a stretcher, oxygen or other special medical arrangements; or (4) the Covered Person's immediate Transportation from the place where he or she suffers an Injury or Emergency Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained; or (5) the Covered Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Emergency Sickness and being treated at a local hospital or other medical facility; or (6) both (4) and (5) above. A Medical Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Emergency Sickness means an illness or disease, diagnosed by a Doctor, which meets all of the following criteria: (1) there is present a severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of the Covered Person's condition or place his or her life in jeopardy; (2) the severe or acute symptom occurs suddenly and unexpectedly; and (3) the severe or acute symptom occurs while this Policy is in force as to the Covered Person suffering the symptom.

Medically Necessary Medical Evacuation Service means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of an Medical Evacuation due to the Injury or Emergency Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Doctor and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Covered Person.

Transportation means moving the Covered Person during a Medical Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

SECTION 7 - EXCLUSIONS AND LIMITATIONS

This Policy does not cover nor provide benefits for Loss or Expenses incurred:

1. as a result of dental treatment, or dental x-rays except as provided elsewhere in this Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
2. for services normally provided without charge by this Policyholder's Health Service, Infirmary or Hospital, or by health care providers employed by this Policyholder or services covered by the Student Health Center fee.
3. for eye examinations, eyeglasses, contact lenses, or prescription for such except for aphakic patients (including lenses required after cataract surgery and soft lenses or sclera shells to treat Sickness or Injury); radial keratotomy or laser surgery; hearing aids or prescriptions or examinations for such except as required for repair caused by a covered Injury. Eye refraction is not covered. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
4. for hearing examinations or hearing aids; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing apart from the disease process.
5. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.
6. for Injury or Sickness resulting from war or act of war, declared or undeclared.
7. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.
8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.
9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.
10. for cosmetic surgery. "Cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.
11. for preventive treatment, testing, medicines, serums, vaccines, or vitamins, except as specifically provided in this Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
12. as a result of committing or attempting to commit an assault or felony or participation in a riot or civil commotion.
13. for Elective Treatment or elective surgery unless otherwise provided in this Policy.
14. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.
15. for any services rendered by a Covered Person’s Immediate Family Member.
16. for any treatment, service or supply which is not Medically Necessary.
17. as a result of suicide or any attempt at suicide or intentionally self-inflicted Injury or any attempt at intentionally self-inflicted Injury.

18. for treatment of temporomandibular joint dysfunction except as specifically provided in this Policy
19. for Injury caused by, contributed to or resulting from the Covered Person's use of alcohol, illegal drugs or use of legal medicines that are not taken in the dosage of or for the purpose as prescribed by the Covered Person's Doctor.
20. for surgery and/or treatment of: acupuncture; gynecomastia; allergy, including allergy testing; biofeedback-type services; breast implants or breast reduction unless Medically Necessary following a mastectomy; circumcision; corns, calluses and bunions (except capsular or bone surgery); deviated nasal septum, including submucuous resection and/or other surgical correction thereof; family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; hair growth or removal; impotence, organic or otherwise; learning disabilities; nonmalignant warts, moles and lesions unless Medically Necessary; premarital examinations; sexual reassignment surgery and related therapy; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; sleep disorders; vasectomy; and weight reduction. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
21. for routine physical examinations, health examinations or preschool physical examinations, including routine care of a newborn infant, well-baby care and related Doctor charges, except as specifically provided for in this Policy. This exclusion does not apply to Preventive Services mandated by the Patient Protection and Affordable Care Act.
22. for sterilization or sterilization reversal, including surgical procedures and devices, except as specifically provided.
23. as a result of a motor vehicle accident if the Covered Person is not properly licensed to operate the motor vehicle within the jurisdiction in which the Accident takes place, except in a Driver's Education program.
24. for organ, transplants except as specifically provided.
25. for voluntary or elective abortions.
26. for Physiotherapy except as specifically provided under this Policy.
27. for Injury resulting from: the practicing for, participating in intercollegiate or professional sports activity, including travel to and from the activity and practice; racing or speed contests; skin diving; hang gliding; parasailing; sky diving; glider flying; sail planing; parachuting; or bungee jumping.
28. for rest cures or custodial care.
29. for treatment of obesity, except resulting from diabetes, regardless of the history or diagnosis, including, but not limited to the following: weight reduction or dietary control programs; prescription or nonprescription drugs or medications such as vitamins (whether taken orally or by injection), minerals, appetite suppressants, or nutritional supplements; and any complication resulting from weight loss treatments or procedures.
30. for the services of an assistant surgeon except as specifically provided under this Policy.
31. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.
32. for treatment, service or supply for which a charge would not have been made in the absence of insurance.
33. for any private duty nursing services rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN), except as specifically provided.
34. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.

SECTION 7 - EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS: Expenses incurred by a Covered Person as a result of a Pre-existing Condition will not be considered Eligible Expenses unless no charges are incurred or treatment rendered for the condition for a period of twelve months of continuous coverage while covered under this Policy.

This limitation will not apply if, during the period immediately preceding the Covered Person's effective date of coverage under this Policy, the Covered Person was covered under prior Creditable Coverage for 12 consecutive months. Prior Creditable Coverage of less than 12 months will be credited toward satisfying the Pre-existing Condition limitation. This waiver of Pre-existing Condition limitation will apply only if the Covered Person becomes eligible and enrolls for coverage within 63 days of termination of his or her prior coverage.

Pre-existing Conditions limitation does not apply to:

(a) a newborn Dependent child; or
(b) a child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while covered under this Policy, and the child has not attained 18 years of age;
(c) pregnancy; or
(d) a Covered Person under age nineteen (19).

Items (a) and (b) above shall not apply to a newborn child or child who is adopted or placed for adoption after the end of the first 63 day period, during all of which the newborn child or child who is adopted or placed for adoption was not covered under any Creditable Coverage.

CREDIT FOR PRIOR COVERAGE: A Covered Person whose coverage under prior Creditable Coverage ended no more than 63 days before the Covered Person's effective date under this Policy, will have any applicable Pre-Existing Condition limitation reduced by the total number of days the Covered Person was covered by such coverage. If there was a break in Creditable Coverage of more than 63 days, the Company will credit only the days of such coverage after the break.

Creditable Coverage means coverage under any of the following:

(a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
(b) Title XVIII, part A or B, of the Social Security Act, 42 U.S.C. 1395a through 1395i-4 or 42 U.S.C. 1395j through 1395w-4;
(c) Title XIX of the Social Security Act, 42 U.S.C. 1396a through 1396u, other than coverage consisting solely of a benefit under section 1928, 42 U.S.C. 1396s;
(d) Chapter 55 of Title 10, United States Code;
(e) a medical care program of the Indian Health Service or of a tribal organization;
(f) a health plan offered under chapter 89 of Title 5, United States Code;
(g) a public health plan*; or
(h) a health benefit plan under section 5(e) of the Peace Corps Act, 22 U.S.C. 2504(e);
(i) a high risk pool in any state.

*A public health plan is defined as any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverages to individuals who are enrolled in the plan.

SECTION 8 - APPEAL PROCEDURES

DEFINITIONS:

Adverse Determination: A determination by the Company or its designee that the health care services furnished or proposed to be furnished to a Covered Person are:

(a) not Medically Necessary, as determined by the Company, or its designee or Experimental/Investigational, as determined by the Company, or its designee; and
(b) benefit coverage is therefore denied, reduced or terminated.

It does not mean a determination by the Company or its designee that the Health Care Services furnished or proposed to be furnished to a Covered Person are specifically limited or excluded in the Covered Person's health care plan.

Authorized Representative: An individual who the Covered Person willingly acknowledges to represent his or her interests during an appeal process. The Covered Person may be required to submit written verification of his or her consent to be represented. If the Covered Person has been determined by a Doctor to be incapable of assigning the right of representation, the appeal may be filed by a family member or a legal representative.

Coverage Denial: The determination made by the Company that a service, treatment, drug, or device is specifically limited or excluded under the Covered Person's health benefit plan.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of the Covered Person in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

External Review: A review that is conducted by an Independent Review Organization which meets specified criteria as established in §44-301.8 of the District of Columbia Insurance Related Laws.

Grievance: A written request by a Covered Person, or his or her Authorized Representative, or Health Care Provider acting on behalf of the Covered Person, for review of a decision of the Company or its designee to deny, reduce, limit, terminate or delay covered Health Care Services to a Covered Person.

Health Care Provider: A Doctor; health care professional who is licensed, registered, to provide Health Care Services in the ordinary care of business or practice; a health care facility as defined by the laws of the state to operate as a health care facility; or a pharmacy.

Health Care Services: Items or services provided under the supervision of a Doctor or other person trained or licensed to render health care necessary for the prevention, care, diagnosis, or treatment of human disease, pain, Injury, deformity or other physical or mental condition including the following: pre-admission, outpatient, inpatient, and post-discharge care; home care; Doctor's care; nursing care; medical care provided by interns or residents in training; other paramedical care; ambulance service and care; bed and board; drugs, supplies; appliances, equipment; laboratory services; any form of diagnostic imaging or therapeutic radiological services; and services mandated under Chapter 31 of Title 31of the District of Columbia Insurance Code.

Independent Review Organization: An impartial, certified health entity engaged by the Director of the Department of Health Care Finance to review any Adverse Determination by the Company or its designee, including the decision to deny, terminate, or limit covered Health Care Services.

DEFINITIONS: (continued)

Internal Appeal Process: A process, in accordance with District of Columbia statutes, established and maintained by the Company, its designee, or agent whereby the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, may contest an Adverse Determination rendered by the Company or its designee.

Urgent Medical Condition: a condition which, if not treated within 24 hours, could reasonably be expected to result in (1) placing the health of the Covered Person in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

INTERNAL APPEAL PROCESS:

Informal Internal Review. The Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, may submit an oral or written request for an Informal Internal Review to the Company within 30 days after an event that gives rise to the Grievance. The Company must respond to the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, within fourteen (14) business days. If the Informal Internal Review appeal is not resolved to the satisfaction of the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, the Company will give written notification of the Adverse Determination and of the right to proceed to the next stage of the Internal Appeal Process. The written notice shall contain:

(a) the reviewer's understanding of the Grievance;
(b) the reviewer's decision in clear terms;
(c) the contractual basis or medical rationale in enough detail for the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, to understand and respond to the Company's or its designee's position; and
(d) all applicable instructions, including the telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

If an appeal is from an Adverse Determination regarding an Urgent Medical Condition or Emergency Medical Condition, the Company will render its decision within twenty-four (24) hours of receipt of the appeal from the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf.

Formal Internal Review. When the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, is dissatisfied with the Adverse Determination rendered by the Company, the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, has the right to pursue an appeal before a reviewer or panel of Doctors, or advanced practice registered nurses, or other health care professionals selected by the Company or its designee.

The reviewer or panel selected by the Company or its designee shall not have been involved in the Adverse Determination that is the subject of the appeal. For all reviews requiring medical expertise, the reviewer or panel shall include at least one medical reviewer who is trained or certified in the same specialty as the matter at issue.

The medical reviewer shall be a Doctor, or an advanced practice registered nurse or other appropriate Health Care Provider possessing a non-restricted license to practice or provide care anywhere in the United States and have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body. The medical reviewer shall be certified by a recognized specialty board in the areas appropriate to review.

INTERNAL APPEAL PROCESS: (continued)

All Formal Internal Review appeals shall be acknowledged by the Company or its designee, in writing, to the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, filing the appeal within ten (10) business days of receipt.

All Formal Internal Review appeals shall be concluded as soon as possible after receipt by the Company or its designee of all necessary documentation in accordance with the medical exigencies of the case. If the Formal Internal Review appeal is from an Adverse Determination regarding an Urgent Medical Condition or Emergency Medical Condition, the Company or its designee will conclude the appeal within twenty-four (24) hours notification of appeal by the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf. All other appeals will be concluded within thirty (30) business days, except, that the time may be extended at the request of the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf.

If the Company renders an Adverse Determination, the Company will issue a written explanation of its decision to the Covered Person and, if applicable, his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf as well as written notification of the right to an External Review. The notification shall include specific instructions as to how to make arrangements for an External Review and shall also include any forms required to initiate the External Review.

The written explanation shall include:

(1) the reviewer's understanding of the nature of the Grievance and all pertinent facts;
(2) the reviewer's decision in clear terms;
(3) the contractual basis or medical rationale in enough detail for the Covered Person, or his or her Authorized Representative or Health Care Provider acting on the Covered Person's behalf, to understand and to respond to the Company's or its designee's position; and
(4) notice of the Covered Person's right to an External Review with instructions, including telephone numbers and titles of persons to contact and time frames to appeal the decision to the next stage of appeal.

In the event that the Company or its designee fails to comply with any of the deadlines for completion of a Formal Internal Review appeal, the Covered Person, or his or her Authorized Representative or Health Care Provider acting on the Covered Person's behalf, shall be relieved of his or her obligation to complete the Formal Internal Review appeal process and may, at his or her option, proceed directly to the External Review process.

EXTERNAL REVIEW PROCESS:

When the Company provides notice to a Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, of Adverse Determination and the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, is dissatisfied with the decision rendered in the Formal Internal Review process, he or she shall have the opportunity to pursue an External Review before an Independent Review Organization. To initiate an External Review appeal, the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, must file a written request with the Director of the Department of Health Care Finance within four months of receipt of the written notice of the Adverse Determination from the Company or its designee. The Covered Person, or his or her Authorized Representative or Health Care Provider acting on the Covered Person's behalf shall submit a signed form allowing the Company or its designee to release medical records that are pertinent to the appeal.

EXTERNAL REVIEW PROCESS: (continued)

Upon receipt of the request for an External Review, together with the executed release form, the Director of the Department of Health Care Finance shall determine whether:

(a) the Covered Person was or is covered under the health benefit plan;

(b) the Health Care Service which is the subject of the appeal reasonably appears to be a service covered under the health benefit plan;

(c) the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, has exhausted the Company's Internal Appeal Process; and

(d) all necessary information required by the Independent Review Organization and the Director of the Department of Health Care Finance to make a preliminary determination, including the appeal form, and a copy of any information provided by the Company or its designee regarding its Adverse Determination, and the required release form.

Upon completion of the preliminary review, the Director of the Department of Health Care Finance shall notify in writing the Covered Person, his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, as to whether the appeal has been accepted for processing. If the appeal is accepted by the Director of the Department of Health Care Finance, the Director of the Department of Health Care Finance shall assign the appeal to an Independent Review Organization for full review. If the appeal is not accepted by the Director of the Department of Health Care Finance, the Director of the Department of Health Care Finance shall provide a statement of the reasons for the non-acceptance to the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, and the Company or its designee.

The Director of the Department of Health Care Finance may waive exhaustion of the Internal Appeal Process as a prerequisite for proceeding to the External Review process in cases of an Urgent Medical Condition or Emergency Medical Condition.

The Company or its designee will provide timely access to all its records relating to the matter under review and to all provisions of the health benefit plan or health insurance coverage, including any evidence of coverage relating to the matter.

Upon acceptance of the appeal for processing, the Independent Review Organization shall conduct a full review to determine whether, as a result of the Company's or its designee's Adverse Determination, the Covered Person was deprived of any service covered under the health benefit plan.

The full review of an appeal of the Adverse Determination shall be initially conducted by at least two (2) Doctors licensed to practice medicine in the District of Columbia, Maryland or Virginia. On an exceptions basis, when necessary based on the medical, surgical or mental condition under review, the Independent Review Organization may select medical reviewers licensed anywhere in the United States who have no history of disciplinary action or sanctions pending or taken against them by any governmental or professional regulatory body.

In reaching a determination, the Independent Review Organization shall take into consideration all pertinent medical records, consulting Doctor reports, and other documents submitted by the parties, any applicable generally accepted practice guidelines developed by the federal government, national or professional medical societies, boards and associations, any applicable clinical protocols or practice guidelines developed by the Company or its designee, and may consult with such other professionals as appropriate and necessary.

EXTERNAL REVIEW PROCESS: (continued)

The Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, may request to appear in person before the Independent Review Organization. The Independent Review Organization shall conduct the hearing in the District of Columbia. The procedures for conducting a review when the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, has requested to appear in person, shall include the following:

(a) the Independent Review Organization shall schedule and hold a hearing as soon as possible after receipt of the request from the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, or from the Company or its designee, to appear before the Independent Review Organization. The Independent Review Organization shall give notification, either orally or in writing, of the hearing date and location. The Independent Review Organization shall not unreasonably deny a request for postponement of the hearing made by the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, or the Company or its designee;

(b) the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, shall have the right to the following:
  (1) to attend the Independent Review Organization hearing;
  (2) to present his or her case to the Independent Review Organization;
  (3) to submit supporting material both before and during the hearing;
  (4) to ask questions of any representative of the Independent Review Organization; and
  (5) to be assisted or represented by a person of his or her choice.

When necessary, the Independent Review Organization shall consult with a Doctor or advance practice registered nurse trained in the same specialty or area of practice as the type of treatment that is the subject of the Grievance and appeal. All final recommendations of the Independent Review Organization shall be approved by the Medical Director of the Independent Review Organization.

The Independent Review Organization shall complete its review and issue its recommended decision as soon as possible in accordance with the medical exigencies of the case. The Independent Review Organization shall complete its review and provide written notice of the final external review decision within thirty (30) business days, or within seventy-two (72) hours in the case of an expedited appeal, from the time the Director of the Department of Health Care Finance assigns the appeal to the Independent Review Organization. The Company or its designee shall provide all documentation to the Independent Review Organization within five (5) days of receipt of the notice of approval of the appeal by the Director of the Department of Health Care Finance, or within twenty-four (24) hours of receipt of the notice of approval of the Grievance, for an expedited review. If the Company or its designee does not provide the Independent Review Organization all documentation required within the time frames, or obtain the necessary extensions, the Independent Review Organization may decide the appeal without receiving the information. The Independent Review Organization shall extend its review for a reasonable period of time as may be necessary due to circumstances beyond its or the Company's or its designee's control, but only when the delay will not result in increased medical risk to the Covered Person. In such an event, the Independent Review Organization shall, prior to the conclusion of the initial review period, provide written notice to the Covered Person, or his or her Authorized Representative, or Health Care Provider acting on the Covered Person's behalf, and the Company setting forth the status of its review and specific reasons for the delay.

If the Independent Review Organization determines that the Covered Person was deprived of Medically Necessary covered services, the Independent Review Organization shall recommend to the Director of the Department of Health Care Finance the appropriate covered Health Care Services the Covered Person should receive. The Director of the Department of Health Care Finance shall forward copies of the recommendation to the Covered Person, or his or her Authorized Representative, or Health Care Provider and the Company.

EXTERNAL REVIEW PROCESS: (continued)

When necessary, the Independent Review Organization shall refer a case for review to a consultant Doctor or other Health Care Provider in the same specialty or area of practice who would generally manage the type of treatment that is the subject of the appeal. All final recommendations of the Independent Review Organization shall be approved by the Medical Director of the Independent Review Organization.

The decision of the Independent Review Organization shall be nonbinding on all parties and shall not affect any other legal causes of action.

Any appeal brought by a Covered Person involving coverage provided under a Medicaid program shall be resolved in accordance with federal and District of Columbia laws, regulations and procedure established for fair hearings and appeals for the Medicaid program.

A Covered Person may make a written or oral request of an expedited external review with the examiner at the time the Covered Person receives:

- An Adverse Determination that involves an Emergency Medical Condition; and the Covered Person has filed a request for an expedited internal appeal; or
- An Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility; and the Covered Person has filed a request for an expedited internal appeal; or
- A final internal Adverse Determination that involves an Emergency Medical Condition; or
- A final internal Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility.

If the Covered Person is dissatisfied with the resolution reached through the insurer's internal grievance system regarding medical necessity, he or she may contact the Director, Office of the Health Care Ombudsman and Bill of Rights at the following:

For Medical Necessity cases:
District of Columbia Department of Health Care Finance
Office of the Health Care Ombudsman and Bill of Rights
899 North Capital Street, N.E.
6th Floor
Washington, D.C. 20002
1 (877) 685-6391
Fax: (202) 478-1397

If the Covered Person is dissatisfied with the resolution reached through the insurer's internal grievance system regarding all other grievances, he or she may contact the Commissioner at the following:

For Non -Medical Necessity cases:
Commissioner: William P. White
Executive Director: Robert M. Willis
Department of Insurance, Securities and Banking
810 First St. N.E., 7th Floor
Washington, D.C. 20002
202-727-8000
Fax: (202) 354-1085

IMPORTANT NOTICE

Your student health insurance coverage, offered by National Union Fire Insurance Company of Pittsburgh, Pa., may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits.

The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: $500,000 on Essential Health Benefits.

If you have any questions or concerns about this notice, contact Summit America Insurance Services at 800-890-8755.

Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

APPLICATION FOR STUDENT BLANKET ACCIDENT AND SICKNESS INSURANCE POLICY

HOWARD UNIVERSITY
(the Policyholder)

2244 10th STREET NW, SUITE 402, WASHINGTON, DC 20059
(Policyholder's Address)

CAS9495454	**CHH0091424**
(Policy Number)	**(Reference Number)**

applies for the following insurance under and in accordance with the Student Blanket Accident and Sickness Policy:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

ACCIDENT AND SICKNESS EXPENSE BENEFIT

COVERAGE PROVISIONS:

NEEDLESTICK AND SPLATTER EXPENSE
HOSPITAL EXPENSE
SURGICAL EXPENSE
IN-HOSPITAL DOCTOR'S FEES EXPENSE
OUTPATIENT EXPENSE
OUT OF HOSPITAL DOCTOR'S FEES EXPENSE
CONSULTANTS FEES EXPENSE
AMBULANCE EXPENSE
DENTAL TREATMENT EXPENSE – INJURY ONLY
DENTAL TREATMENT EXPENSE
DENTAL TREATMENT EXPENSE FOR IMPACTED WISTOM TEETH
SECOND SURGICAL OPINION EXPENSE
PRESCRIBED MEDICINES EXPENSE
HOME HEALTH CARE EXPENSE
HOSPICE CARE EXPENSE
MATERNITY TESTING EXPENSE
ORAL ANTI CANCER MEDICATION
SUBSTANCE ABUSE AND MENTAL ILLNESS EXPENSE
DIABETES EXPENSE
MAMMOGRAPHY AND CERVICAL CYTOLOGICAL SCREENING
COLORECTAL CANCER SCREENING
BREAST CANCER TREATMENT
RECONSTRUCTIVE BREAST SURGERY
PROSTATE CANCER SCREENING
VOLUNTARY HIV SCREENING TEST EXPENSE
EMERGENCY CARE
CHILD HEALTH SUPERVISION SERVICES
CLINICAL TRIALS EXPENSE
HABILITATIVE SERVICES FOR CHILDREN
NEWBORN HEARING IMPAIRMENT SCREENING

REPATRIATION OF REMAINS EXPENSE BENEFIT
MEDICAL EVACUATION EXPENSE

Policyholder Riders and/or Endorsements:
The following Riders and/or Endorsements are attached to and made part of the Policy as of the Policy Effective Date. Each Rider and/or Endorsement is subject to all provisions, limitations and exclusions of the Policy that are not specifically modified by the Rider and/or Endorsement.

FORM NO.	DESCRIPTION
89644(7/05)	Coverage Territory Endorsement

Premiums:
It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

	Plan A	Plan B
Student	$699	$1,079
Spouse	$1,972	$3,044
Child(ren)	$1,016	$1,568

This application is attached to, and made part of, the Student Blanket Accident and Sickness Insurance Policy.

The Student Blanket Accident and Sickness Policy has been approved, and its terms accepted, by the Policyholder.

No change in the Policy shall be valid unless approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

Policy Effective Date: **August 1, 2013**
Policy Termination Date: **July 31, 2014**

Dated at _____ 2013

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

_____
Signed for the Policyholder

_____
Title

_____
Date

_____
Signed by Licensed Resident Agent
(Where Required by Law)

SERFF Tracking #:	*AGDE-129138343*	***State Tracking #:***		***Company Tracking #:***	*NUFIC13CAS01 - RATE*

State:	*District of Columbia*	***Filing Company:***	*National Union Fire Insurance Company of Pittsburgh, Pa.*
TOI/Sub-TOI:	*H04 Health - Blanket Accident /Sickness/H04.001 Student*		
Product Name:	*Educational Markets*		
Project Name/Number:	*Howard University Single Case filing/NUFIC13CAS01*		

Rate Information

Rate data applies to filing.

Filing Method:	Review and approval
Rate Change Type:	Neutral
Overall Percentage of Last Rate Revision:	%
Effective Date of Last Rate Revision:	
Filing Method of Last Filing:	

Company Rate Information

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where req'd):	Minimum % Change (where req'd):
National Union Fire Insurance Company of Pittsburgh, Pa.	New Product	%	%				%	%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

State: *District of Columbia* **Filing Company:** *National Union Fire Insurance Company of Pittsburgh, Pa.*

TOI/Sub-TOI: *H04 Health - Blanket Accident /Sickness/H04.001 Student*
Product Name: *Educational Markets*
Project Name/Number: *Howard University Single Case filing/NUFIC13CAS01*

Rate Review Detail

COMPANY:

Company Name: National Union Fire Insurance Company of Pittsburgh, Pa.
HHS Issuer Id: 00000
Product Names: Group Blanket Accident and Sickness Insurance Policy
Trend Factors: 7.1%

FORMS:

New Policy Forms: S30749NUFIC-DC-HU; S30753NUFIC-DC-HU
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 0
Benefit Change:
Percent Change Requested: Min: Max: Avg:

PRIOR RATE:

Total Earned Premium:
Total Incurred Claims:
Annual $: Min: Max: Avg:

REQUESTED RATE:

Projected Earned Premium: 6,352,552.00
Projected Incurred Claims: 4,713,594.00
Annual $: Min: 50.67 Max: 230.50 Avg: 55.17

SERFF Tracking #:	*AGDE-129138343*	***State Tracking #:***		***Company Tracking #:***	*NUFIC13CAS01 - RATE*

State:	*District of Columbia*	***Filing Company:***	*National Union Fire Insurance Company of Pittsburgh, Pa.*
TOI/Sub-TOI:	*H04 Health - Blanket Accident /Sickness/H04.001 Student*		
Product Name:	*Educational Markets*		
Project Name/Number:	*Howard University Single Case filing/NUFIC13CAS01*		

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		Rate Manual	S30749NUFIC-DC-HU	New		RM-Howard_Single Case Filing2013-2014.pdf,

RATE MANUAL

POLICY FORM S30749NUFIC-DC-HU

APPLICATION FORM S30753NUFIC-DC-HU

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

National Union Fire Insurance Company of Pittsburgh, PA.

Rate Manual for Group Blanket Accident and Sickness Insurance Policy

Policy Holder - Howard University
School Year 2013/2014 Rates

	Plan A (Basic Plan)		
	Fall Only	Spring/Summer	Annual
Student	$304	$304	$608
Spouse	$890	$890	$1,780
Children	$451	$451	$901

	Plan B (Enhanced Plan)		
	Fall Only	Spring/Summer	Annual
Student	$480	$480	$959
Spouse	$1,383	$1,383	$2,766
Children	$704	$704	$1,408

These are the rates excluding Agent fees

SERFF Tracking #:	*AGDE-129138343*	***State Tracking #:***		***Company Tracking #:***	*NUFIC13CAS01 - RATE*

State:	*District of Columbia*	***Filing Company:***	*National Union Fire Insurance Company of Pittsburgh, Pa.*
TOI/Sub-TOI:	*H04 Health - Blanket Accident /Sickness/H04.001 Student*		
Product Name:	*Educational Markets*		
Project Name/Number:	*Howard University Single Case filing/NUFIC13CAS01*		

Supporting Document Schedules

Satisfied - Item:	Cover Letter All Filings
Comments:	The cover letter information is contained in the filing discription area of the general information tab of this SERFF filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Certificate of Authority to File
Bypass Reason:	Not applicable as this is not a third party filer.
Attachment(s):	
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Memorandum
Comments:	
Attachment(s):	AM-Howard_Single Case Filing2013-2014.pdf
Item Status:	
Status Date:	

Satisfied - Item:	Actuarial Justification
Comments:	Rates have been attached to the rate schedule tab of this SERFF filing. The actuarial memorandum is attached in the above supporting documentation item. The actuarial memorandum contains language on pages 5 and 6 to certify that to the best of their knowledge and judgment that such justification is true.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	District of Columbia and Countrywide Loss Ratio Analysis (P&C)
Bypass Reason:	Not applicable as this is not a P&C filing.
Attachment(s):	
Item Status:	
Status Date:	

SERFF Tracking #:	*AGDE-129138343*	***State Tracking #:***		***Company Tracking #:***	*NUFIC13CAS01 - RATE*

State:	*District of Columbia*	***Filing Company:***	*National Union Fire Insurance Company of Pittsburgh, Pa.*
TOI/Sub-TOI:	*H04 Health - Blanket Accident /Sickness/H04.001 Student*		
Product Name:	*Educational Markets*		
Project Name/Number:	*Howard University Single Case filing/NUFIC13CAS01*		

Bypassed - Item:	District of Columbia and Countrywide Experience for the Last 5 Years (P&C)
Bypass Reason:	Not applicable as this is not a P&C filing.
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Not applicable as instructions state bypass for initial submission
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Actuarial Memorandum and Certifications
Bypass Reason:	Not applicable Per our understanding, student health insurance is exempt from federal rate review process and therefore we do not need to file the Part I Unified Rate Review Template
Attachment(s):	
Item Status:	
Status Date:	

Bypassed - Item:	Unified Rate Review Template
Bypass Reason:	Not applicable as this is not a QHP.
Attachment(s):	
Item Status:	
Status Date:	

ACTUARIAL MEMORANDUM

POLICY FORM S30749NUFIC-DC-HU

APPLICATION FORM S30753NUFIC-DC-HU

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

National Union Fire Insurance Company of Pittsburgh, PA.

Actuarial Memorandum for Group Blanket Accident and Sickness Insurance Policy

Item1. Scope & Purpose

This rate filing is to justify rates charged for a single policyholder, Howard University (Howard), to cover the accident and sickness related medical expenses of its undergraduate and graduate students.

Item 2. Benefit Description

This is a Group Blanket Accident and Sickness Insurance policy to be issued to Howard University. This policy provides accident and sickness related medical benefit coverage to the Howard eligible college students and their spouses and children. The detailed descriptions of benefits are included in Exhibit A.

Item 3. Renewability

The Policy is issued for a stated Policy Term. The Company or Policyholder can terminate the policy by giving written notice as described in the policy.

Item 4. Applicability

The rates apply for the school year 2013/2014.

Item 5. Morbidity

The proposed 2013/14 school year premium rates were developed from 2011/12 school year and 2012/13 school year claim experience. The detailed step by step derivation of the proposed rates is displayed in Exhibit B. The following adjustments to the past experience were used at the time of rate projection.

1. Benefit change adjustment: The total impact due to benefit changes is -12.6%.
2. Trend: An annual medical trend of 7.1% was selected for both 2012/13 school year and 2011/12 school year. Both school years were trended to the midpoint of 2013/14 school year.
3. Weighting of 2012/13 school year and 2011/12 school year ultimate claim experience: 56.9% and 43.1% weight was applied to 2012/13 and 2011/12 school years' ultimate losses, respectively. Weighting for school year 2012/13 is 1 / (cumulative loss development factor). Weighting for 2011/12 is equal to 1 – weight for school year 2012/13.

Item 6. Mortality

This is a twelve month term product. Mortality assumptions were not used in the pricing of this product.

Item 7. Persistency

This is a twelve month term product. Persistency assumptions were not used in the pricing of this product.

Item 8. Expenses and Commissions

The expected expenses (excluding PPACA fees and taxes) are as follows:

Expense Category	% of Premium
Commission and Brokerage	0.00%
Claims Administration	*5.00%*
Premium Taxes, Licenses, Fees, etc.	*2.52%*
Home Office Administration	*7.71%*
Profits and Contingencies	*5.00%*
Total Expenses	**20.23%**

Item 9. Marketing

The program is made available to students through the University.

Item 10. Underwriting Method

As this is a blanket insurance policy, all students and dependents who meet the eligibility requirements are able to enroll. There is no individual medical underwriting of the insureds.

Item 11. Premium Classes

Premium rates are shown in the Rate Manual.

Item 12. Issue Age Limits and Coverage Duration

Benefits will be offered to all qualified applicants regardless of age.

Coverage begins of the Effective Date as described in the policy and ends at the end of semester or school year for which coverage was purchased, subject to any Extended Coverage provision of the Policy.

Item 13. Area Factors

There are no area factors.

Item 14. Average Annual Premium

The estimated average premium for school year 2013/2014 is $662.

Item 15. Premium Modalization Rules

Premiums are stated as annual. Premium splits by semester are shown in the Rate Manual.

Item 16. Claim Liability and Reserves

Claim reserves will be set using appropriate actuarial methodology.

Item 17. Active Life Reserves

No Active Life Reserves will be held for this coverage.

Item 18. Trend Assumption

The medical trend is 7.1%.

Item 19. Interest Rate Assumption

No interest rate assumption is used.

Item 20. Minimum Required Loss Ratio

The minimum required loss ratio is determined by PPACA. Under PPACA, this program is considered Individual business with a medical loss ratio of 80%. Loss ratios under PPACA are calculated as (see 45 CFR 158.211):

Incurred Claims, divided by Earned Premium, less federal taxes, less PPACA fees and taxes, and less state and local taxes, licenses and fees.

In determining a Loss Ratio for pricing purposes the federal and state taxes must be projected. For federal taxes, we assume a federal tax rate of 35%. For state and local taxes, licenses, fees and assessments, we use the historical average for this Company. The impact of these adjustments is to lower the actual Loss Ratio. This calculation produced a required minimum loss ratio of 70.98%. The details of this calculation:

National Union Fire Insurance Company of Pittsburgh, PA.

Actuarial Memorandum for Group Blanket Accident and Sickness Insurance Policy

	Item	Expressed as a % of Premium	Source
A	Minimum Loss Ratio	80.0%	This is considered Individual business under PPACA
B	Profit	5.0%	Assumed Profit
C	FIT Rate	35.0%	Corporate Marginal Tax Rate
D	Federal Taxes	1.75%	=B*C
E	Taxes, Fees, Assessments directly related to PPACA	7.0%[1]	Includes PCORI Fee of $2.00 PPPY; Reinsurance Fee of $5.25 PPPM; Health Industry Fee of 2.1% of Premium
F	State Taxes, Licenses, Fees	2.52%	Derived from most recent Annual Statement
G	Adjusted Minimum Loss Ratio	70.98%	=A*(1-(D+E+F)), rounded to 4 places

1

PPACA Fees / Taxes	Annual Fees	Comments	
IRS Regulation 26 CFR §46.4375: Patient-Centered Outcomes Research Institute (PCORI)- ($2.00 annual /head)	2		
Section 1341 of PPACA: Transitional Reinsurance Program ($63 per year per head or $5.25 per month per head)	36.75	=5.25 x 7 Months = 5.25 x 7	PPACA Fees and Taxes starts on 1/1/2014 - PPACA fees /taxes starting apply; end on 7/31/2014 for Howard University school year 2013/2014; Approximately 7 months premium are affected by PPACA fees and taxes
Section 9010 of PPACA, Health Insurance Industry tax (2.1% annual)	7.55	=Indicated Premium before PPACA Fees/Taxes x 2.1% x 7Months/12 Months 1141 x 2.1% x 7/12	
Total PPACA Fees/Taxes	**46.30**	=2+36.75+7.55 (rounded to 2 decimals)	
PPACA Fees/Taxes as % of Projected Premium	**7.0%**	= projected PPACA Fees & Taxes/Projected Premium =46 / 662	

In performing this calculation, we did not include other items that also lower the loss ratio, such as expenses for activities that improve the quality of health care.

Item 21. Anticipated Loss Ratio

Under PPACA, the medical loss ratio of this policy is 83.6% (=Projected Claim Costs Per Person/ [Projected Premium Per Person x (1- Federal Tax % - State Tax % - Taxes, Fees, Assessments directly related to PPACA %)].

The anticipated loss ratio including PPACA fees and Taxes is 74.2% (= Projected Claim Cost Per Insured / Projected Premium Per Insured).

Item 22. Lifetime Loss Ratio

The lifetime loss ratio is 74.2%.

Item 23. History of Rate Adjustments

This is a new form. There have been no rate adjustments under this form.

Item 24. Number of Policyholders

The estimated number of students to be insured for school year 2013/2014 is 9,596.

Item 25. Proposed Effective Date

These rates are effective 8/1/2013.

Item 26. Actuarial Certification

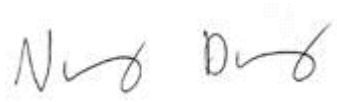
I am a Member of the American Academy of Actuaries. I meet the “Qualification Standards for Actuaries Issuing Statements of Actuarial Opinion” as adopted by the American Academy of Actuaries.

National Union Fire Insurance Company of Pittsburgh, PA.

Actuarial Memorandum for Group Blanket Accident and Sickness Insurance Policy

I certify that to the best of my knowledge and belief:

- The entire filing is in compliance with the applicable laws of this state;
- The entire filing is in compliance with all applicable Actuarial Standards of Practice;
- The benefits provided are reasonable in relation to the proposed premiums; and
- The premium schedule is not excessive, inadequate, or unfairly discriminatory



Ning Ding, FSA, MAAA
Fellow, Society of Actuaries
Member, American Academy of Actuaries
July, 2013

National Union Fire Insurance Company of Pittsburgh, PA.
Actuarial Memorandum for Group Blanket Accident and Sickness Insurance Policy

Exhibit A

Schedule of Benefits	**Benefit Amount**	
PLAN A		
Note: Students must first seek treatment at the Howard University Student Health Center when enrolled as an eligible student. The student must use the services of the Health Center first where treatment will be administered, or referral issued, except when a student graduates from the university and that student is no longer eligible for services at the SHC.		
Aggregate Maximum Benefit per Policy Year	$500,000	
Deductible per person per Policy Year (All copays are in addition to the deductible.)	$200 In-Network Deductible; $400 Out-of-Network Deductible	
INPATIENT	**Injury Maximum Amount**	**Sickness Maximum Amount**
Room & Board Expense (includes Intensive Care), limited to the average semi-private room rate; (includes general nursing care).	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Hospital Miscellaneous, includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays, (including professional fees); oxygen tent; drugs, medicines, dressings; and other Medically Necessary and prescribed hospital expenses.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Intensive care	Paid under Room & Board Expense.	Paid under Room & Board Expense.
Pre-admission Testing, hospital confinement must occur within 3 days of the testing.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Registered Nurse (for private duty nursing.)	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	No Benefits
Physiotherapy	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Surgery, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures performed.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Assistant Surgeon's Fees	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	No Benefits
Anesthesia, professional services administered in connection with inpatient surgery.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Doctor's Visits (other than the Doctor who performed surgery or administered anesthesia), limited to one visit per day.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Routine Newborn Care, while hospital confined and routine nursery care provided immediately after birth.	Paid as any other sickness.	Paid as any other sickness.
Substance Abuse/Mental Illness Expense, including all related and ancillary charges.	No benefits.	Paid as any other sickness.
OUTPATIENT		
Surgeon's Fees, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures performed.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Assistant Surgeon's Fees	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	No Benefits

Exhibit A

Schedule of Benefits	**Benefit Amount**	
PLAN A		
Anesthesia, professional services administered in connection with outpatient surgery.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	25% of amount payable for surgery.
Day Surgery Miscellaneous., when scheduled surgery is performed in a Hospital or outpatient facility including use of the operating room, laboratory tests and x-ray examinations (including professional fees), anesthesia, infusion therapy; drugs or medicines and supplies, therapeutic services (excluding physiotherapy or take home drugs and medicines) . R&C charges for Day Surgery Misc. are based on the most recent edition of the Outpatient Surgical Facility Charge Index.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Outpatient Misc. Benefits includes: physiotherapy; occupational therapy; laboratory; x-ray exams; CAT Scans/MRI; and diagnostic services and medical procedures.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Doctor's Visits, limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.	After a $25 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	After a $25 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Hospital Emergency Room and Non-Scheduled Surgery, for use of hospital emergency room, operating room, laboratory and x-ray exams, and supplies.	After a $250 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	After a $250 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Injections when administered in the Doctor's office and charged on the Doctor's statement.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	For contraceptive injections only: 100% of Allowable Charges for PPO providers, otherwise 80% of R&C.
Prescribed Medicine Expense, includes prescribed contraceptive drugs, devices and injectables. Benefits include FDA-approved prescribed birth control methods.	100% of actual charge if filed with Summit America Insurance Services. If Script Care RX card is used then 100% of R&C after applicable co-pay amount per prescription. **Co-pay per prescription/refill: Generic: $15, Brand: $30, Non-Formulary: $55**	Script Care participating pharmacies only: 100% of R&C after applicable co-pay amount per prescription otherwise, No Benefits. **Co-pay per prescription/refill: Generic: $15, Brand: $30, Non-Formulary: $55** **Co-pays waived for prescribed birth control.**
Substance Abuse/Mental Illness Expense, including all related and ancillary charges. SHC referral not required for Mental Illness.	No Benefits.	Paid as any other Sickness.
OTHER		
Ambulance Services (for Emergency Medical Condition only).	100% of R&C.	100% of R&C.
Durable Medical Equipment and Orthopedic Appliances, a written prescription must accompany the claim when submitted. Replacement durable medical equipment is not covered. Replacement braces and appliances are not covered except for repair or replacement that is required by a changed condition due to Sickness or Injury.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C

Exhibit A

Schedule of Benefits	**Benefit Amount**	
PLAN A		
Consultant Doctor's Fees, when requested and approved by the attending Doctor.	After a $25 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.	After a $25 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 80% of R&C.
Dental Treatment Expense, for dental treatment made necessary by Injury to sound natural teeth up to $250 per tooth.	80% of R&C.	No Benefits.
Dental Treatment Expenses, for preventative, diagnostic, basic restorative, and major replacement when obtained in the Howard University Outpatient Clinic at the College of Dentistry.	No Benefits.	100% of Eligible Expenses at College of Dentistry only, otherwise, No Benefits.
Dental Treatment Expense for Impacted Wisdom Teeth	No Benefits.	Included in Surgeon's Fees
Maternity/Complications of Pregnancy	No Benefits.	Paid as any other sickness.
Needlestick and Splatter Expense	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C	No Benefits.
Radiation and Chemotherapy	No Benefits.	100% of the Allowable Charges for PPO providers, otherwise 80% of R&C
Immune Titers, (available at the Student Health Center only) not otherwise covered under Preventive Services benefit.	No Benefits.	After a $10 co-pay, 100% of Eligible Expenses at Student Health Center, otherwise, No Benefits
Wellness Benefit (including annual adult physical exam, routine testing, well woman exams and visits not otherwise covered under Preventive Services benefit.)	No Benefits.	100% of Eligible Expenses at Student Health Center or at PPO providers, otherwise, No Benefits
Preventive Services Benefit, includes preventive services such as screenings, exams, and immunizations specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services go to http://www.hhs.gov/healthcare/prevention/index.html.	100% of Allowable Charges for PPO Providers, otherwise, No Benefits.	100% of Allowable Charges for PPO Providers, otherwise, No Benefits.
Medical Evacuation and Repatriation of Body Remains, Combined maximum limit for Evacuation and Repatriation of Remains and family or friend transportation arrangements in conjunction with the evacuation or repatriation of remains when necessary and approved by Travel Guard.	100% of actual expense to a maximum of $25,000.	

Exhibit A

Schedule of Benefits	**Benefit Amount**	
PLAN B		
Note: On Plan B, a referral from the Howard University Student Health Center is not required. The student may seek the health care facility of their choice. The Policy provides benefits for the Reasonable and Customary Charges (R&C) incurred by a Covered Person for loss due to a covered Injury or Sickness up to the Basic Aggregate Maximum Benefit of $500,000 per Injury or Sickness. Benefits will be paid up to the Basic Aggregate Maximum Benefit Amount for each service as scheduled below subject to the Injury or Sickness Basic Aggregate Maximum Benefit.		
INPATIENT	**Injury Maximum Amount**	**Sickness Maximum Amount**
Room & Board Expense (includes Intensive Care), limited to the average semi-private room rate; (includes general nursing care).	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise $200 per day.
Hospital Miscellaneous, includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays, (including professional fees); oxygen tent; drugs, medicines, dressings; and other Medically Necessary and prescribed hospital expenses.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Intensive care	Paid under Room & Board Expense.	Paid under Room & Board Expense.
Pre-admission Testing, hospital confinement must occur within 3 days of the testing.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Registered Nurse (for private duty nursing.)	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	No Benefits
Physiotherapy	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Surgery, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures performed.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Assistant Surgeon's Fees	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	No Benefits
Anesthesia, professional services administered in connection with inpatient surgery.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Doctor's Visits (other than the Doctor who performed surgery or administered anesthesia), limited to one visit per day.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Routine Newborn Care, while hospital confined and routine nursery care provided immediately after birth.	Paid as any other sickness.	Paid as any other sickness.
Substance Abuse/Mental Illness Expense, including all related and ancillary charges.	No benefits.	Paid as any other sickness.
OUTPATIENT		
Surgeon's Fees, when Injury or Sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, the Company will pay only for the most expensive when multiple procedures performed.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Assistant Surgeon's Fees	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	No Benefits
Anesthesia, professional services administered in connection with outpatient surgery.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.

Exhibit A

Schedule of Benefits	**Benefit Amount**	
PLAN B		
Day Surgery Miscellaneous., when scheduled surgery is performed in a Hospital or outpatient facility including use of the operating room, laboratory tests and x-ray examinations (including professional fees), anesthesia, infusion therapy; drugs or medicines and supplies, therapeutic services (excluding physiotherapy or take home drugs and medicines) . R&C charges for Day Surgery Misc. are based on the most recent edition of the Outpatient Surgical Facility Charge Index.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Outpatient Misc. Benefits includes: physiotherapy; occupational therapy; laboratory; x-ray exams; CAT Scans/MRI; and diagnostic services and medical procedures.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Doctor's Visits, limited to one visit per day. Benefits do not apply when related to surgery or physiotherapy.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Hospital Emergency Room and Non-Scheduled Surgery, for use of hospital emergency room, operating room, laboratory and x-ray exams, and supplies.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	After a $100 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.
Injections when administered in the Doctor's office and charged on the Doctor's statement.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	For contraceptive injections only: 100% of Allowable Charges for PPO providers, otherwise 100% of R&C.
Prescribed Medicine Expense, includes prescribed contraceptive drugs, devices and injectables. Benefits include FDA-approved prescribed birth control methods.	100% of actual charge if filed with Summit America Insurance Services. If Script Care RX card is used then 100% of R&C after applicable co-pay amount per prescription. **Co-pay per prescription/refill: Generic: $15, Brand: $30, Non-Formulary: $55**	Script Care participating pharmacies only: 100% of R&C after applicable co-pay amount per prescription otherwise, No Benefits. **Co-pay per prescription/refill: Generic: $15, Brand: $30, Non-Formulary: $55 Co-pays waived for prescribed birth control.**
Substance Abuse/Mental Illness Expense, including all related and ancillary charges. SHC referral not required for Mental Illness.	No Benefits.	Paid as any other Sickness.
OTHER		
Ambulance Services (for Emergency Medical Condition only).	100% of R&C.	100% of R&C.
Durable Medical Equipment and Orthopedic Appliances, a written prescription must accompany the claim when submitted. Replacement durable medical equipment is not covered. Replacement braces and appliances are not covered except for repair or replacement that is required by a changed condition due to Sickness or Injury.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C
7	After a $25 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.	After a $25 co-pay per visit, 100% of the Allowable Charges for PPO providers, otherwise 100% of R&C.

Exhibit A

Schedule of Benefits	**Benefit Amount**	
PLAN B		
Dental Treatment Expense, for dental treatment made necessary by Injury to sound natural teeth up to $250 per tooth.	80% of R&C.	No Benefits.
Dental Treatment Expenses, for preventative, diagnostic, basic restorative, and major replacement when obtained in the Howard University Outpatient Clinic at the College of Dentistry.	No Benefits.	100% of Eligible Expenses at College of Dentistry only, otherwise, No Benefits.
Dental Treatment Expense for Impacted Wisdom Teeth	No Benefits.	Included in Surgeon's Fees
Maternity/Complications of Pregnancy	No Benefits.	Paid as any other sickness.
Needlestick and Splatter Expense	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C	No Benefits.
Radiation and Chemotherapy	No Benefits.	100% of the Allowable Charges for PPO providers, otherwise 100% of R&C
Immune Titers, (available at the Student Health Center only) not otherwise covered under Preventive Services benefit.	No Benefits.	After a $10 co-pay, 100% of Eligible Expenses at Student Health Center, otherwise, No Benefits
Wellness Benefit (including annual adult physical exam, routine testing, well woman exams and visits not otherwise covered under Preventive Services benefit.)	No Benefits.	100% of Eligible Expenses at Student Health Center or at PPO providers, otherwise, No Benefits
Preventive Services Benefit, includes preventive services such as screenings, exams, and immunizations specified by the Patient Protection and Affordable Care Act (PPACA). To view a list of covered preventive services go to http://www.hhs.gov/healthcare/prevention/index.html.	100% of Allowable Charges for PPO Providers, otherwise, No Benefits.	100% of Allowable Charges for PPO Providers, otherwise, No Benefits.
Medical Evacuation and Repatriation of Body Remains, Combined maximum limit for Evacuation and Repatriation of Remains and family or friend transportation arrangements in conjunction with the evacuation or repatriation of remains when necessary and approved by Travel Guard.	100% of actual expense to a maximum of $25,000.	
Accidental Death and Dismemberment	$10,000	

National Union Fire Insurance Company of Pittsburgh, Pa.

Actuarial Memorandum for Group Blanket Accident and Sickness Insurance Policy

Exhibit B

Policy Holder - Howard University

Previous Program Experience

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Experience Period	# of Insureds	Average Annual Premium Rate	Earned Premium	Current Level E.P.	Paid Claims	Completed Claims	Loss Ratio	Trend at 7.1%	Historical Benefit Adjustment	Trended and Onlevel Claims	Ultimate on-leveled and Trended Loss Ratio	Experience Weight
8/1/2011 - 7/31/2012	10,251	481	4,926,852	7,236,978	4,155,890	4,233,471	85.9%	1.147	1.228	5,964,437	82.4%	43.1%
8/1/2012 - 7/31/2013 Est.	9,596	706	6,774,843	6,774,843	2,790,971	4,905,500	72.4%	1.071	1.000	5,253,791	77.5%	56.9%

Column	Description
(1)	Period of coverage from which experience is derived.
(2)	Number of students covered during experience period.
(3)	Annual premium rate charged for coverage during specified experience period.
(4)	Premium earned during experience period.
(5)	Premium during experience period adjusted to current rate level.
(6)	Claims paid to date for incurrals during experience period.
(7)	Estimated completed claims for experience period, including claim reserve.
(8)	Experience period loss ratio, (7)/(4)
(9)	Trend factor based on 7.1% annual rate and years from experience period to 8/2013-8/2014 rating period.
(10)	Adjustment to bring benefit design value to 8/2012-8/2013 level
(11)	Claims adjusted for trend and benefit design, (7)x(9)x(10)
(12)	Loss ratio based on claims and premiums adjusted to current level, (11)/(5)
(13)	Weights applied to each experience period for future premium rate determination.

Rate Determination

	(14)=(2)	(15)=(11)	(16)	(17)=(15)x(16)/(14)	(18)
Experience Period	# of Insureds	Trended and onleveled Claim	Factor to adjust claims to projected cost level	Projected Claim Costs Per Insured	Experience Weight
8/1/2011 - 7/31/2012	10,251	5,964,437	0.874	508.30	43.1%
8/1/2012 - 7/31/2013 Est.	9,596	5,253,791	0.874	478.28	56.9%

Weighted average projected claim cost per insured		491.22
Target Loss Ratio	Divide	79.77%
Projected Premium Rate Per Person		616
PPACA Fees and Taxes	Plus	46.30
Final Projected Premium Rate Per Person		662

SERFF Tracking #:	*AGDE-129138343*	***State Tracking #:***		***Company Tracking #:***	*NUFIC13CAS01 - RATE*

State:	*District of Columbia*	***Filing Company:***	*National Union Fire Insurance Company of Pittsburgh, Pa.*
TOI/Sub-TOI:	*H04 Health - Blanket Accident /Sickness/H04.001 Student*		
Product Name:	*Educational Markets*		
Project Name/Number:	*Howard University Single Case filing/NUFIC13CAS01*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/30/2013		Form	Student Blanket Accident and Sickness Policy	08/16/2013	S30494NUFIC-NM-UNM .pdf (Superceded)
07/30/2013		Form	Application for Student Accident and Sickness Insurance Policy	08/16/2013	S30501NUFIC-NM.pdf (Superceded)

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

Policyholder: The University of New Mexico

Policy Number: CAS9495331
Reference Number: CHH0058674

STUDENT BLANKET ACCIDENT AND SICKNESS POLICY

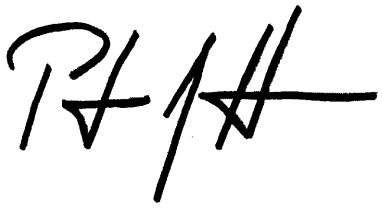
This Policy is a legal contract between the Policyholder and the Company. The Company agrees to insure eligible persons of the Policyholder against loss covered by this Policy subject to its provisions, limitations and exclusions. This Policy provides accident and sickness insurance to Covered Persons. The persons eligible to be Covered Persons are all persons described in the Description of Class section of the Schedule of Benefits.

This Policy is issued in consideration of payment of the required premium when due and the statements set forth in the signed Application For Student Blanket Accident and Sickness Insurance Policy which is attached to and made part of this Policy.

This Policy begins on the Policy Effective Date shown in the Schedule of Benefits and continues in effect until the Policy Termination Date as long as premiums are paid when due, unless otherwise terminated as further provided in this Policy. If this Policy is terminated, insurance ends on the date to which premiums have been paid.

This Policy is governed by the laws of the state in which it is delivered.

The President and Secretary of National Union Fire Insurance Company of Pittsburgh, Pa. witness this Policy:



President

Secretary

NON-RENEWABLE ONE-YEAR TERM INSURANCE

PLEASE READ THIS POLICY CAREFULLY

Non-Participating Policy

TABLE OF CONTENTS

SECTION 1 - SCHEDULE OF BENEFITS

***Policyholder Effective Date:** **July 15, 2013 (earliest)**
***Policyholder Termination Date:** **August 18, 2014 (latest)**

*Specific Effective and Termination Dates:

- July 15, 2013 – July 14, 2014 for Students enrolled in the Medical Doctorate Program; or
- July 16, 2013 – July 14, 2014 for Students enrolled in the Medical Doctorate Program maintaining continuous coverage from the prior Policy Year; or
- August 19, 2013 – August 18, 2014 for all regular students; or
- August 20, 2013 – August 18, 2014 for Covered Students maintaining continuous coverage from the prior Policy Year; or
- If elected and additional premium is paid, up to 3 weeks prior to August 19, 2013 for Students who arrive on campus early. Termination Date is August 18, 2014.

Eligible persons in the Description of Class below may elect, provided the appropriate premium is paid, the benefit plan described in PLAN A or PLAN B.

A Covered Person who elects to enroll in Plan A will be allowed to change to Plan B at a semester renewal only. A Covered Person will not be allowed to upgrade from Plan B to Plan A during any Policy Year. Coverage must be the same for the Covered Student and his or her Dependents.

DESCRIPTION OF CLASS

(a) All University of New Mexico students enrolling **(and not receiving a tuition refund)**, paying fees and actively attending classes each semester for 6 or more credit hours or 3 hours in the summer;

(b) Any University of New Mexico student officially registered at a branch campus, or for a cooperative education work phase class;

(c) Formally established special groups, as determined by the University of New Mexico Student Health and Counseling and the Company (such as international programs); and

(d) Students of University of New Mexico who are Graduate Assistants, Teaching Assistants, Project Assistants, or Research Assistants. (Home study, correspondence and television courses do not fulfill credit hour requirements.)

SECTION 1 - SCHEDULE OF BENEFITS

COVERAGE **BENEFIT AMOUNT**

PLANS A OR B

Subject to the terms of this Policy, Benefits will be provided only for the coverages indicated below; and only up to the amounts shown.

A Preferred Provider Organization (PPO) is an organization in which a group of Hospitals and Doctors have agreed to provide medical care services to Covered Persons. The PPO for this Policy will be selected by the Company. The PPO provides these services according to negotiated fee schedules that are considered full payment for services rendered, subject to policy provisions. A Covered Person has the option to use a PPO provider or a non-PPO provider. Benefits applicable to both types of providers are shown below.

For treatment or care received outside the PPO geographic service area, benefits for Eligible Expense will be payable at the non-PPO level. However, if such treatment is received in a non-PPO facility because of an Emergency Medical Condition; or the service to be performed was not available at a Preferred Provider, benefits for Eligible Expenses are payable at the PPO level..

Benefits payable under the Policy for covered services rendered through the Preferred Provider Organization (PPO) network shall be based on the Allowable Charges of its providers.

Benefits payable under the Policy for covered services rendered outside the Preferred Provider Organization (Non-PPO) network shall be based on the Reasonable and Customary charges of the providers.

Emergency Services treatment or care rendered by a Non-PPO provider is mandated by the Patient Protection and Affordable Care Act to be provided at the same benefit and cost sharing level as services provided by PPO provider.

ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN A

Basic Aggregate Maximum Benefit per Accident or Sickness per Policy Year	$500,000
***Deductible Amount per Policy Year**	
Per Covered Person	$250
Per Family	$500

*The Deductible Amounts above do not apply to the Eligible Expenses incurred at the Student Health Center.

	PPO	**Non-PPO**
***Covered Percentage:**	80%	70%

*The Covered Percentage for Eligible Expenses incurred for any service rendered at the Student Health Centers will be payable at 70%.

Benefits for Eligible Expenses will be payable at the PPO level if:
(a) the Covered Student is more than 50 miles away from Albuquerque; or
(b) the service to be performed is not available at a PPO provider.

COVERAGE	BENEFIT AMOUNT	
ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN A (continued)	**PPO**	**Non-PPO**

The Covered Percentages above apply to all Eligible Expenses, except as otherwise indicated in the Schedule of Benefits below, until $5,000 has been paid. Thereafter, the Covered Percentage will be raised to 100% of Eligible Expenses up to the Basic Aggregate Maximum Benefit per Accident or Sickness. Where indicated in the Schedule of Benefits, the Reasonable and Customary charge will be determined on the basis of the Fair Health, Inc. survey of prevailing fees valued at the 90th percentile for PPO and at the 80th percentile for Non-PPO.

ACCIDENT AND SICKNESS ELIGIBLE EXPENSES INCLUDE:

HOSPITAL EXPENSE

- Daily Room and Board Maximum — Average Semi-private Rate
- Intensive Care
- Hospital Miscellaneous
- Pre-Admission Testing (Hospital Confinement must occur within 3 days of the testing)
- Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is: rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service.
- Physiotherapy during Hospital Confinement

***SURGICAL EXPENSE (Inpatient or Outpatient)**

Anesthetist

Assistant Surgeon

*For Covered Students only, surgery to remove non-malignant warts, moles and lesions will be covered at the Student Health Center only.

IN-HOSPITAL DOCTOR'S FEES EXPENSE

OUTPATIENT EXPENSE

Day Surgery Facility/Miscellaneous

When scheduled surgery is performed in a Hospital or outpatient facility, including the use of the operating and recovery room, laboratory tests and x-ray examinations (including professional fees), anesthesia, drugs or medicines and supplies. Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the most recent edition of the Outpatient Surgical Facility Charge Index.

Hospital Emergency Room and Non-Scheduled Surgery

For use of Hospital Emergency Room, operating room and supplies.

***For Laboratory and X-ray Examinations**

*Not otherwise covered under Preventive Benefits

For Radiation Therapy and Chemotherapy

COVERAGE ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN A (continued)	BENEFIT AMOUNT PPO	 Non-PPO
OUTPATIENT EXPENSE (Continued)		
***For diagnostic services and medical procedures performed by the Doctor (other than Doctor's visits, physiotherapy, x-rays and lab procedures).** *Not otherwise covered under Preventive Benefits		
For Physiotherapy Services must commence within 30 days immediately following the attending Doctor's release for rehabilitation (including acupuncture, manipulation, heat treatment and massage performed by a Doctor, therapist or chiropractor).		
Covered Percentage		
Student Health Center Only	70%	
Other than Student Health Center	50%	
Maximum Number of Visits per Day	1	
Maximum Number of Visits per Accident or Sickness	10* **	

*When services are rendered at the Student Health Center, the Maximum Number of Visits will be increased to 15 per Accident or Sickness.

**Massage Therapy is limited to two (2) treatments per semester, six (6) treatments per Policy Year, up to $240 Maximum Amount per Policy Year.

For Occupational Therapy	Included in the Physiotherapy benefit	
***For Durable Medical Equipment and Orthopedic Appliances** *Benefits are payable only upon Doctor's written prescription. Replacements and dental appliances are not covered. The Company has the right to pay the lesser of the purchase price or rental.		
***For Benefits for Preventive Services mandated by the Patient Protection and Affordable Care Act**		
Covered Percentage	100%	N/A
*This benefit is not subject to the Deductible Amount per Policy Year.		

COVERAGE ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN A (continued)	BENEFIT AMOUNT PPO	 Non-PPO

***OUT OF HOSPITAL DOCTOR'S FEES EXPENSE**

Maximum Number of Visits per Day 1

Includes:

- Injections (not routine or otherwise covered under Preventive Benefits), including allergy Injections if administered at the Student Health Center only.
- Immunizations and Vaccines (not otherwise covered under Preventive Benefits) For Students only, when administered at the Student Health Center only.

*Benefits do not apply when related to surgery or physiotherapy, except at the Student Health Center.

CONSULTANT'S FEES EXPENSE

AMBULANCE EXPENSE

DENTAL EXPENSE (Injury Only)

Maximum Amount per Tooth $150

***OPTIONAL DENTAL TREATMENT EXPENSE**

If elected by the Covered Person during initial enrollment and the appropriate premium is paid, the Covered Person will be eligible for the Optional Dental Treatment Expense benefit described below. Only a Covered Person who is enrolled in the Basic Plan may become eligible under the Optional Dental Treatment Expense.

Maximum Amount per Policy Year	$1,000
Optional Dental Treatment Deductible Amount per Policy Year	$50
Covered Percentage	
For Preventive Services	100%**
For Basic Services	80%
For Major Services	50%

This coverage does not include Orthodontic Services for which treatment began prior to the Effective Date, nor will benefits be paid for Gold Foil Restoration, Gold Fillings, Inlays, Crowns, Bridges, and Dentures.

*This benefit is not subject to the Deductible Amount per Policy Year.
**The Optional Dental Treatment Deductible Amount does not apply.

COVERAGE ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN A (continued)	BENEFIT AMOUNT PPO	 Non-PPO
PRESCRIBED MEDICINES EXPENSE		
(Limited to a 30 day supply per prescription)		
Covered Percentage:		
*Prescribed Contraceptives:		
**Student Health Center	100%	
Outside Student Health Center	50%	N/A
All other Prescribed Medicines:		
**Student Health Center	50%	
Outside Student Health Center	50%	
Aggregate Maximum Amount per Policy Year	$500,000***	

Outside of the Student Health Center, Prescription Benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person's Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic.

*This benefit applies to all prescribed FDA-approved birth control methods.

**This benefit is not subject to the Deductible Amount per Policy Year.

***However obtained, all prescription drugs are subject to the Prescribed Medicines Expense Aggregate Maximum Amount per Policy Year.

ABORTION EXPENSE

MENTAL AND NERVOUS DISORDERS EXPENSE

ALCOHOLISM AND SUBSTANCE ABUSE EXPENSE

OPTIONAL VISION CARE EXPENSE

If elected by the Covered Person during initial enrollment and the appropriate premium is paid, the Covered Person will be eligible for the Optional Vision Care Expense benefit described below. Only a Covered Person who is enrolled in the Basic Plan may become eligible under the Optional Vision Care Expense.

Optional Vision Care Deductible Amount per Policy Year:	$50
Covered Percentage	100%
Maximum Amount	$250

*This benefit is not subject to the Deductible Amount per Policy Year.

SECTION 1 - SCHEDULE OF BENEFITS

COVERAGE	**BENEFIT AMOUNT**
ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN B	
Basic Aggregate Maximum Benefit per Accident or Sickness per Policy Year	$500,000
***Deductible Amount per Policy Year**	
Per Covered Person	$1,500
Per Family	$2,000

*The Deductible Amounts above do not apply to the Eligible Expenses incurred at the Student Health Center.

	PPO	**Non-PPO**
***Covered Percentage:**	80%	70%

*The Covered Percentage for Eligible Expenses incurred for any service rendered at the Student Health Centers will be payable at 70%.

Benefits for Eligible Expenses will be payable at the PPO level if:
(a) the Covered Student is more than 50 miles away from Albuquerque; or
(b) the service to be performed is not available at a PPO provider.

The Covered Percentages above apply to all Eligible Expenses, except as otherwise indicated in the Schedule of Benefits below, until $5,000 has been paid. Thereafter, the Covered Percentage will be raised to 100% of Eligible Expenses up to the Basic Aggregate Maximum Benefit per Accident or Sickness. Where indicated in the Schedule of Benefits, the Reasonable and Customary charge will be determined on the basis of the Fair Health, Inc. survey of prevailing fees valued at the 90th percentile for PPO and at the 80th percentile for Non-PPO.

ACCIDENT AND SICKNESS ELIGIBLE EXPENSES INCLUDE:

HOSPITAL EXPENSE

- Daily Room and Board Maximum — Semi-private Rate
- Intensive Care
- Hospital Miscellaneous
- Pre-Admission Testing (Hospital Confinement must occur within 3 days of the testing)
- Private Duty Nursing rendered by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) provided such care is: rendered during Hospital Confinement; (b) Medically Necessary; and (c) no other charge is made for such service.
- Physiotherapy during Hospital Confinement

***SURGICAL EXPENSE (Inpatient or Outpatient)**
Anesthetist

Assistant Surgeon

*For Covered Students only, surgery to remove non-malignant warts, moles and lesions will be covered at the Student Health Center only (if there is a change in size and/or color).

COVERAGE ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN B (continued)	BENEFIT AMOUNT PPO	 Non-PPO

IN-HOSPITAL DOCTOR'S FEES EXPENSE

OUTPATIENT EXPENSE

Day Surgery Facility/Miscellaneous
When scheduled surgery is performed in a Hospital or outpatient facility, including the use of the operating and recovery room, laboratory tests and x-ray examinations (including professional fees), anesthesia, drugs or medicines and supplies. Reasonable and Customary Charges for Day Surgery Miscellaneous are based on the most recent edition of the Outpatient Surgical Facility Charge Index.

Hospital Emergency Room and Non-Scheduled Surgery
For use of Hospital Emergency Room, operating room and supplies.

***For Laboratory and X-ray Examinations**

*Not otherwise covered under Preventive Benefits

For Radiation Therapy and Chemotherapy

***For diagnostic services and medical procedures performed by the Doctor (other than Doctor's visits, physiotherapy, x-rays and lab procedures).**

*Not otherwise covered under Preventive Benefits.

For Physiotherapy
Services must commence within 30 days immediately following the attending Doctor's release for rehabilitation (including acupuncture, manipulation, heat treatment and massage performed by a Doctor, therapist or chiropractor).

Covered Percentage	
Student Health Center Only	70%
Other than Student Health Center	50%
Maximum Number of Visits per Day	1
Maximum Number of Visits per Accident or Sickness	10*

*When services are rendered at the Student Health Center, the Maximum Number of Visits will be increased to 15 per Accident or Sickness.

For Occupational Therapy — Included in the Physiotherapy benefit

***For Durable Medical Equipment and Orthopedic Appliances**
*Benefits are payable only upon Doctor's written prescription. Replacements and dental appliances are not covered. The Company has the right to pay the lesser of the purchase price or rental.

COVERAGE ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN B (continued)	BENEFIT AMOUNT PPO	 Non-PPO
OUTPATIENT EXPENSE (Continued)		
***For Benefits for Preventive Services mandated by the Patient Protection and Affordable Care Act** Covered Percentage	100%	N/A

*This benefit is not subject to the Deductible Amount per Policy Year.

OUT OF HOSPITAL DOCTOR'S FEES EXPENSE	
Maximum Number of Visits per Day	1

*Benefits do not applywhen related to surgery or physiotherapy, except at the Student Health Center.

CONSULTANT'S FEES EXPENSE

AMBULANCE EXPENSE

DENTAL EXPENSE (Injury Only)	
Maximum Amount per Tooth	$150

***OPTIONAL DENTAL TREATMENT EXPENSE**

If elected by the Covered Person during initial enrollment and the appropriate premium is paid, the Covered Person will be eligible for the Optional Dental Treatment Expense benefit described below. Only a Covered Person who is enrolled in the Basic Plan may become eligible under the Optional Dental Treatment Expense.

Maximum Amount per Policy Year	$1,000
Optional Dental Treatment Deductible Amount per Policy Year	$50
Covered Percentage	
For Preventive Services	100%**
For Basic Services	80%
For Major Services	50%

This coverage does not include Orthodontic Services for which treatment began prior to the Effective Date, nor will benefits be paid for Gold Foil Restoration, Gold Fillings, Inlays, Crowns, Bridges, and Dentures.

*This benefit is not subject to the Deductible Amount per Policy Year.
**The Optional Dental Treatment Deductible Amount does not apply.

COVERAGE ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN B (continued)	BENEFIT AMOUNT PPO	 Non-PPO
PRESCRIBED MEDICINES EXPENSE		
(Limited to a 30 day supply per prescription)		
*Prescribed Contraceptives:		
**Student Health Center	100%	
Outside Student Health Center	50%	N/A
All other Prescribed Medicines:		
**Student Health Center	50%	
Outside Student Health Center	50%	
Maximum Amount per Policy Year	$500,000***	

Outside of the Student Health Center, Prescription Benefits are based on a mandatory generic formulary. If the Covered Person or the Covered Person's Doctor chooses a brand-name drug, the Covered Person will pay the difference between the brand-name drug and the generic.

*This benefit applies to all prescribed FDA-approved birth control methods.

**This benefit is not subject to the Deductible Amount per Policy Year.

***However obtained, all prescription drugs are subject to the Prescribed Medicines Expense Maximum Amount per Policy Year

ABORTION EXPENSE

MENTAL AND NERVOUS DISORDERS EXPENSE

ALCOHOLISM AND SUBSTANCE ABUSE EXPENSE

OPTIONAL VISION CARE EXPENSE

If elected by the Covered Person during initial enrollment and the appropriate premium is paid, the Covered Person will be eligible for the Optional Vision Care Expense benefit described below. Only a Covered Person who is enrolled in the Basic Plan may become eligible under the Optional Vision Care Expense.

Optional Vision Care Deductible Amount per Policy Year:	$50
Covered Percentage	100%
Maximum Amount	$250

*This benefit is not subject to the Deductible Amount per Policy Year.

COVERAGE ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLANS A or B	BENEFIT AMOUNT PPO Non-PPO
DIABETES EXPENSE	See Coverage Provisions
SMOKING CESSATION TREATMENT	See Coverage Provisions
CHILDHOOD IMMUNIZATION EXPENSE	See Coverage Provisions
MAMMOGRAPHY AND CYTOLOGICAL SCREENING EXPENSE	See Coverage Provisions
COLORECTAL CANCER SCREENING EXPENSE	See Coverage Provisions
RECONSTRUCTIVE BREAST SURGERY	See Coverage Provisions
PROSTATE CANCER SCREENING	See Coverage Provisions
TMJ EXPENSE	See Coverage Provisions
HEARING AIDS EXPENSE	See Coverage Provisions
TREATMENT OF INBORN ERRORS OF METABOLISM EXPENSE	See Coverage Provisions
EMERGENCY CARE EXPENSE	See Coverage Provisions
DENTAL ANESTHESIA EXPENSE	See Coverage Provisions
MATERNITY TESTING EXPENSE	See Coverage Provisions
EARLY CHILDHOOD INTERVENTION SERVICES EXPENSE	See Coverage Provisions
CLINICAL TRIALS EXPENSE	See Coverage Provisions
AUTISM SPECTRUM DISORDER EXPENSE	See Coverage Provisions

REPATRIATION OF REMAINS EXPENSE BENEFIT
Maximum Amount per Injury or Sickness $1,000,000*

*In no event will the Maximum Amount payable for Repatriation of Remains exceed $1,000,000 when combined with the amount paid for Medical Evacuation.

***MEDICAL EVACUATION EXPENSE BENEFIT**
Maximum Amount per Injury or Sickness $1,000,000**

*Benefits will be considered only after being hospitalized for a least 5 consecutive days (3 days for mental health).

**In no event will the Maximum Amount payable for Medical Evacuation exceed $1,000,000 when combined with the amount paid for Repatriation of Remains.

SECTION 2 - DEFINITIONS

Whenever used in this Policy:

"**Accident**" means an occurrence which (a) is unforeseen; (b) is not due to or contributed to by Sickness or disease of any kind; and (c) causes Injury.

"Act" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

"Allowable Charges" means the charges agreed to by the Preferred Provider Organization for specified covered medical treatment, services and supplies.

"**Complications of Pregnancy**" means conditions which require Hospital stays before the pregnancy ends and whose diagnoses are distinct from but are caused or affected by pregnancy. These conditions are:
- acute nephritis or nephrosis; or
- eclampsia; puerperal infection; or
- RH Factor problems; or
- severe loss of blood requiring transfusion; or
- cardiac decompensation or missed abortion; or
- similar conditions as severe as these.
- non-elective cesarean section; and
- termination of an ectopic pregnancy; and
- spontaneous termination when a live birth is not possible. (This does not include voluntary or elective abortion)

Not included are: (a) false labor, occasional spotting or Doctor prescribed rest during the period of pregnancy; (b) morning sickness; (c) hyperemesis gravidarum and pre-eclampsia; and (d) similar conditions not medically distinct from a difficult pregnancy.

"Covered Percentage" means the portion of the Eligible Expense that is payable as a benefit under this Policy.

"**Covered Person**" means a Covered Student and his or her Dependent(s) insured under this Policy.

"**Covered Student**" means a student of the Policyholder who is insured under this Policy.

"Deductible/Deductible Amount" means the dollar amount of Eligible Expenses a Covered Person must pay before benefits become payable.

"**Dependent**" means: (a) the Covered Student's Spouse residing with the Covered Student; and (b) the Covered Student's child under age 26.

The term "child" includes:
(a) a Covered Student's legally adopted child;
(b) child who has been placed in the Covered Student's home pending adoption procedures; and
(c) a Covered Student's step-child if such child resides with the Covered Student.

The "child" of the Covered Student will not be denied enrollment under this Policy because he or she:
(a) was born out of wedlock;
(b) is not claimed as a dependent on the Covered Student's federal tax return; or
(c) does not reside, other than a step-child, with the Covered Student or in this Policy's service area.

The term “child” includes a child of the Covered Student who is a noncustodial parent. In such case, the Company will:

(a) provide the custodial parent, upon request, any information that is necessary to obtain benefits for such child under such coverage;

(b) permit the custodial parent or the health care provider, with the custodial parent’s approval, to submit claims for Eligible Expenses without the approval of the noncustodial parent. If the provider submits the claim, the provider will obtain the custodial parent’s assignment of insurance benefits or otherwise secure the custodial parent’s signature; and

(c) make payments on claims submitted to such custodial parent, health care provider or the state Medicaid agency, whichever is applicable.

The term “child” also includes a child for whom the Covered Student is required by a court or administrative order to provide coverage. In the event such is the case, the Covered Student may apply to insure the child, if he or she is otherwise eligible for coverage, without regard to any enrollment requirements. Insurance will become effective for such child on the date the Company receives the request. If the Covered Student is eligible for Dependent insurance but fails to apply to insure the child in accordance with the court or administrative order, such child will become insured on the date the Company receives the written request to insure the child from the child’s other parent, the state agency administering the Medicaid program or the state agency administering 42 U.S.C. 651-669, the child enforcement program.

"**Doctor**" as used herein means: (a) legally qualified physician licensed by the state in which he or she practices; and (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of such practitioner; and (c) certified nurse midwives and licensed midwives while acting within the scope of that certification. The term “Doctor” does not include a Covered Person’s Immediate Family Member.

"**Durable Medical Equipment**" consists of, but is not restricted to, the initial fitting and purchase of braces, trusses and crutches, renal dialysis equipment, hospital-type beds, traction equipment, wheelchairs and walkers. Durable Medical Equipment must be prescribed by the attending Doctor and be required for therapeutic use.

The following items are not considered to be Durable Medical Equipment: adjustments to vehicles, air conditioners, dehumidifiers and humidifiers, elevators and stair glides, exercise equipment, handrails, improvements made to a home or place of business, ramps, telephones, whirlpool baths, and other equipment which has both a non-therapeutic and therapeutic use.

"**Elective Treatment**" means medical treatment, which is not necessitated by a pathological change in the function or structure in any part of the body, occurring after the Covered Person's effective date of coverage.

Elective treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction unless as a result of mastectomy; sexual reassignment surgery; submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered acute purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; botox injections; treatment of infertility and routine physical examinations.

"Eligible Expense" as used herein means a charge for any treatment, service or supply which is performed or given under the direction of a Doctor for the Medically Necessary treatment of a Sickness or Injury: (a) not in excess of the Reasonable and Customary charges; or (b) not in excess of the charges that would have been made in the absence of this coverage; (c) is the negotiated rate, if any and (d) incurred while this Policy is in force as to the Covered Person except with respect to any expenses payable under the Extension of Benefits Provision.

SECTION 2 - DEFINITIONS

"**Emergency Medical Condition**" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in: (a) jeopardy to the person's health or pregnancy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person; or serious jeopardy to the health of the Covered Person's fetus.

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

"Emergency Services" means, with respect to an Emergency Medical Condition:

(a) a medical screening examination (as required under section 1867 of the Social Security Act, 42, U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(b) such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

Emergency does not include the recurring symptoms of a chronic illness or condition unless the onset of such symptoms could reasonably be expected to result in the complications listed above.

"Essential Health Benefits" has the meaning found in section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services,; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

"Experimental/Investigational" means a drug, device or medical care or treatment that meets the following:

(a) the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

(b) the informed consent document used with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase, if such a consent document is required by law;

(c) the drug, device, medical care or treatment or the patient's informed consent document used with the drug, device, medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, if federal or state law requires such review and approval;

(d) reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, it efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(e) reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with standard means of treatment of diagnosis.

Reliable evidence means: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device, medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Eligible Expenses will be considered in accordance with the drug, device, medical care or treatment at the time the Expense is incurred.

"**Hospital**" means a facility which meets all of these tests:
(a) it provides in-patient services for the care and treatment of injured and sick people; and
(b) it provides room and board services and nursing services 24 hours a day; and
(c) it has established facilities for diagnosis and major surgery; and
(d) it is supervised by a Doctor; and
(e) it is run as a Hospital under the laws of the jurisdiction in which it is located; and
(f) it is accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Hospital does not include a place run mainly: (a) as a convalescent home; or (b) as a nursing or rest home; (c) as a place for custodial or educational care; or as an institution mainly rendering treatment or services for: Mental or Nervous Disorders; or substance abuse. The term "Hospital" includes: (a) an ambulatory surgical center or ambulatory medical center; (b) Tertiary Care Facility; and (c) a birthing facility certified and licensed as such under the laws where located. It shall also include rehabilitative facilities if such is specifically for treatment of physical disability.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

“Hospital Confinement/Hospital Confined” means a stay of at least 18 consecutive hours or for which a room and board charge is made.

“Immediate Family Member(s)” means a person who is related to the Covered Person in any of the following ways: Spouse, brother-in-law, sister-in-law, son-in-law, daughter-in-law, mother-in-law, father-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted or stepchild).

“Injury” means bodily injury due to an Accident which: (a) results solely and directly from the Accident; (b) results independently of disease, bodily infirmity or any other causes; (c) is initially treated by a Doctor within 30 days after the Accident; (d) occurs after the Covered Person’s effective date of coverage; and (e) occurs while coverage is in force. All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered one Injury.

"**Intensive Care Unit**" means a designated ward, unit or area within a Hospital for which a specified extra daily surcharge is made and which is staffed and equipped to provide, on a continuous basis, specialized or intensive care or services not regularly provided within such Hospital.

SECTION 2 - DEFINITIONS

“Medical Necessity/Medically Necessary" means that a drug, device, procedure, service or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury based on generally accepted current medical practice in the United States at the time it is provided.

A service or supply will not be considered as Medically Necessary if:

(a) it is provided only as a convenience to the Covered Person or provider; or

(b) it is not the appropriate treatment for the Covered Person's diagnosis or symptoms; or

(c) it exceeds (in scope, duration or intensity) that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or

(d) it is Experimental/Investigational or for research purposes; or

(e) could have been omitted without adversely affecting the patient’s condition or the quality of medical care; or

(f) involves treatment of or the use of a medical device, drug or substance not formally approved by the U.S. Food and Drug Administration (FDA); or

(g) involves a service, supply or drug not considered reasonable and necessary by the Center for Medicare and Medicaid Services Issues Manual; or

(h) it can be safely provided to the patient on a more cost-effective basis such as outpatient, by a different medical professional or pursuant to a more conservative form of treatment.

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

“Mental or Nervous Disorder(s)” means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

"**One Sickness**" means a Sickness and all recurrences and related conditions which are sustained by a Covered Person.

“Open Enrollment Period” means the time period designated by the Policyholder during which the Covered Student may enroll himself or herself and his or her Dependents for coverage under the Policy.

“Orthopedic Brace and Appliance” means a supportive device or appliance used to treat a Sickness or Injury.

“Other Valid and Collectible Insurance” means any of the following group, group-type (such as, but not limited to franchise or blanket), family or individual coverages which provide benefits or services for, or because of, health care: (1) insurance policies; (2) subscriber contracts; (3) uninsured arrangements; (4) coverage through health maintenance organizations and other prepayment, group practice and individual practice plans; (5) medical benefits coverage in automobile “no-fault” and traditional automobile “fault” type contracts; and (6) coverage under a governmental plan or coverage required or provided by law; but not including: (a) a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time); or (b) a plan or law when, by law, its benefits are in excess of those of any private insurance plan or other nongovernmental plan.

"**Personal Item**" is one which is not needed for proper medical care and is used mainly for the purpose of meeting a personal need.

“Physiotherapy” means any form of the following administered by a Doctor for treatment of Sickness or Injury: physical or mechanical; diathermy; ultra-sonic therapy; heat treatment in any form; or manipulation or massage.

"**Policy Year**" means the period of time measured from the Effective date to the Termination Date as shown in the Schedule of Benefits.

“Pre-Admission Testing” means diagnostic tests and services ordered by the attending Doctor as appropriately related to the care and treatment of the Covered Person’s condition in anticipation of a scheduled Hospital Confinement; a Hospital bed has been reserved before the tests are made; and Hospital Confinement begins within 3 days of the tests; and the Covered Person is physically present for the tests. In the event pre-admission testing is ordered by the attending Doctor and the Hospital Confinement is subsequently canceled, benefits for pre-admission testing and services already performed will be covered and benefits will be payable under this Policy based on the available coverage.

“Pre-Existing Condition” means a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended within the 6 months prior to the Covered Person’s effective date of coverage under the Policy or a pregnancy existing on the Covered Person’s effective date of Coverage under the Policy.

“Preventive Services” as mandated by the Patient Protection and Affordable Care Act and, In addition to any other preventive benefits described in the Policy or Certificate, means the following services and without the imposition of any cost-sharing requirements, such as deductibles, copayment amounts or coinsurance amounts to any Covered Person receiving any of the following:

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, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;
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 Covered Person involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to women, such additional preventive care and screenings, not described in paragraph 1 above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

The Company shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

"**Reasonable and Customary**" means the charge, fee or expense which is the smallest of: (a) the actual charge; (b) the charge usually made for a covered service by the provider who furnishes it; (c) the negotiated rate, if any; and (d) the prevailing charge made for a covered service in the geographic area by those of similar professional standing.

“Geographic area” means the three digit zip code in which the services, procedure, devices, drugs, treatment or supplies are provided or a greater area, if necessary, to obtain a representative cross-section of charge for a like treatment, service, procedure, device, drug or supply.

Reasonable and Customary charges also means the percentile of the payment system in effect on the Effective Date. Where appropriate, the Reasonable and Customary charge will be determined on the basis of the Fair Health, Inc. survey of prevailing fees valued at the 90th percentile for PPO and at the 80th percentile for Non-PPO.

"**Sickness**" means disease or illness including related conditions and recurrent symptoms of the Sickness which begins after the effective date of a Covered Person's coverage. Sickness also includes pregnancy and Complications of Pregnancy. All Sicknesses due to the same or a related cause are considered One Sickness.

"**Sound Natural Teeth**" means natural teeth, the major portion of the individual tooth which is present regardless of fillings and is not carious, abscessed, or defective. Sound Natural Teeth will not include capped teeth.

"Spouse" means the person to whom the Covered Person is married. The term "Spouse" wherever used in this Policy shall also mean the Covered Student's domestic partner with whom a domestic partnership has been established attesting to the relationship with another person, providing they are living together and any applicable requirements regarding domestic partnership interdependency have been met. A domestic partnership qualifies if the partners are able to provide a domestic partnership certificate from a city, county or state which offers the ability to register a domestic partnership.

"**Student Health Center**" means any organization, facility or clinic operated, maintained or supported by the Policyholder.

"Tertiary Care Facility" means a Hospital unit which provides complete perinatal care and intensive care of intrapartum and perinatal high-risk patients with responsibilities for coordination of transport, communication, education and data analysis systems for the geographic area served.

SECTION 3 - EFFECTIVE DATE OF COVERAGE

Policy Effective Date. This Policy begins on the Policy Effective Date shown in the signed Application at 12:01 a.m. Standard Time at the address of the Policyholder where this Policy is delivered.

Eligible Persons
Student:
Each student, as determined by the school in which he or she is enrolled, is eligible for coverage under this Policy and may insure himself or herself by enrolling on a form provided for that purpose by the Policyholder.

An eligible student may enroll for coverage for himself or herself only under the following conditions:
(a) during an initial or subsequent Open Enrollment Period; or
(b) as a transfer student, within 31 days of the date of the transfer;or
(c) within 31 days of ineligibility under another Creditable Coverage.

An eligible student must attend classes at the Policyholder's school for the first 31 days of the period for which he or she is enrolled.

The Company maintains the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If it is discovered that the Policy eligibility requirements have not been met, the Company's only obligation is to refund premium, less any claims paid.

Dependent:
A Dependent may become eligible for coverage under the Policy only when the student becomes eligible.

An eligible student may enroll for coverage for his or her Dependent only under the following conditions:
(a) during an initial or subsequent Open Enrollment Period; or
(b) within 31 days of a birth or adoption of a child or placement for adoption of a child; or
(c) as a transfer student, within 31 days of the date of the transfer; or
(d) within 31 days of ineligibility under another Creditable Coverage.

Covered Person's Effective Date
Covered Student:
The coverage of an eligible student who enrolls for coverage under this Policy during an initial Open Enrollment Period, or who enrolls within 31 days of the date of transfer to the Policyholder, shall take effect on the latest of the following dates: (1) the Policy Effective Date; (2) the date for which the first premium for the Covered Student's coverage is received; (3) the date the Policyholder's term of coverage begins; or (4) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits.

The coverage of a student who enrolls for coverage under this Policy during any subsequent Open Enrollment Period shall take effect on the later of the following dates: (1) the date for which the premium for the Covered Student's coverage is received; or (2) the date the Policyholder's term of coverage begins.

However, a student who does not enroll himself or herself during an Open Enrollment Period may not apply for coverage until the next subsequent Open Enrollment Period unless application for coverage is made within 31 days of ineligibility under another Creditable Coverage. As a result of ineligibility under another Creditable Coverage, the student may enroll for coverage for himself or herself. In that case, the insurance for the eligible student becomes effective on the latest of the following dates: (1) the date on which the first premium for the Covered Student's coverage is received; or (2) the date the student becomes a member of an eligible class of persons as described in the Description of Class section of the Schedule of Benefits; or (3) the date the Company gives it written consent.

SECTION 3 - EFFECTIVE DATE OF COVERAGE

Covered Dependent:
A covered Dependent's coverage shall take effect on the later the following dates: (1) the date the coverage for the Covered Student becomes effective; or (2) the date the Dependent is enrolled for coverage, provided premium is paid when due.

A newborn child shall be insured for Injury or Sickness, including the necessary care and treatment of premature birth, medically diagnosed congenital defects and birth abnormalities, and the circumcision of a newborn male, furnished any infant from the moment of birth, and where necessary to protect the life of the infant, transportation, including air transport, to the nearest available Tertiary Care Facility for newly born infants, for an initial period of thirty-one days. To continue the insurance beyond this initial 31 day period, the Covered Student must notify the Company of the birth in writing or adoption in writing and pay any additional premium required for the child's insurance within the 31 day period.

Coverage of an adopted child becomes effective on the earlier of: (a) the date of placement for the purpose of adoption; or (b) the date of entry of an order granting the Covered Student custody of the child for purposes of adoption. Such adopted child shall be insured for Injury or Sickness, including the necessary care and treatment of premature birth, medically diagnosed congenital defects and birth abnormalities and the circumcision of a newborn male. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. The Covered Student must notify the Company of the birth or adoption in writing within 31 days and pay any additional premium required for the adopted child's insurance to continue beyond such the 31 day period.

The Policyholder or its authorized representative agrees to submit to the Company within 20 days after the effective date of each Covered Person's insurance: (1) the name of each person enrolled for coverage hereunder; (2) the effective date of insurance; and (3) the premium paid as to each such Covered Person. The insurance of those Covered Persons whose names and premiums were received more than 20 days after the date the insurance would have become effective will take effect on the date such name and premium is received by the Company or its authorized representative except as provided in the previous paragraph.

Continuously insured means a person has been continuously insured under this Policy and prior Student Health Insurance policies issued to the school. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured except for Expenses payable under prior policies in the absence of this Policy. Previously insured Dependents and students must re-enroll for coverage in order to avoid a break in coverage within 21 days of the end of the prior coverage to maintain coverage for conditions which existed in prior Policy Years. Once a break in continuous insurance occurs, the definition of Injury and Sickness will apply in determining coverage of any condition which existed during such break.

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS, CONTINUATION OF COVERAGE

TERMINATION OF POLICY

The Company may terminate this Policy by giving 30 days advance notice in writing to the Policyholder. This Policy may, at any time, be terminated by mutual written consent of the Company and the Policyholder. This Policy terminates automatically on the earlier of: (1) the Policy Termination Date shown in the Schedule of Benefits; or (2) the premium due date if premiums are not paid when due. Termination takes effect at 11:59 p.m. Standard Time at the Policyholder's address on the date of termination.

The Policy is issued for the Policy Term stated in the Schedule of Benefits on the Effective Date of the Policy. If the Policyholder desires to continue coverage, a new Policy will be issued for a new Policy Term, subject to the then current underwriting requirements.

TERMINATION OF STUDENT COVERAGE

Insurance for a Covered Student will end at 11:59 p.m. on the first of these to occur:

(a) the date this Policy terminates;
(b) the last day for which any required premium has been paid;
(c) the date on which the Covered Student withdraws from the school because of:
    (1) entering the armed forces of any country (Premiums will be refunded on a pro-rata basis, less any claims paid.) when written request is made.); or
    (2) withdrawal from school during the first 15 days (4 days for summer semester) of the period for which enrollment was made. (Premiums will refunded when written request is made within the 15 day (or 4 day) period.); or
    (3) departure from the Policyholder's school for his or her home country. (This applies only during summer break.) Refund will be considered only upon written proof of departure for summer break.

If withdrawal from school is for other than (1) (2) or (3) above, no premium refund will be made. Students will be covered for the policy term for which they are enrolled and for which premium has been paid.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

Note: Each Student must re-enroll each year even in the event the Policy is renewed.

TERMINATION OF DEPENDENT COVERAGE

Insurance for a Covered Student's Dependent will end when insurance for the Covered Student ends.

Insurance for Dependents will also terminate on the first premium due date after any of the following events occur:

(a) with respect to a domestic partnership, the Covered Student or domestic partner sends the other a notice for ending the domestic partnership;
(b) with respect to a domestic partnership, the Covered Student or domestic partner gets married to another person;
(c) with respect to a domestic partnership, the Covered Student or domestic partner stop living together;
(d) end of the month in which status as a Dependent ends;
(e) Dependent insurance is deleted from this Policy (any unearned premium will be refunded); or
(f) at the end of the last period for which any required premium has been paid; or
(g) in the event of a court or administrative order requiring coverage for a Dependent child, the date the court or administrative order is no longer in effect; or the date the Dependent Child's comparable coverage provided through another carrier becomes effective. Satisfactory written evidence of this must be provided to the Company.

SECTION 4 - TERMINATION OF COVERAGE, EXTENSION OF BENEFITS, CONTINUATION OF COVERAGE

The Company will not disenroll or otherwise eliminate coverage of a Dependent child for whom insurance is required by court or administrative order unless the Company is provided satisfactory written evidence that:

(a) such court or administrative order is no longer in effect; or
(b) such Dependent child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment; or
(c) Dependent coverage has been eliminated under this Policy.

Insurance may be continued for incapacitated Dependent children who reach the age at which insurance would otherwise cease. The Dependent child must be:

(a) chiefly dependent upon the Covered Student for support; and
(b) incapable of self-sustaining employment because of mental or physical handicap.

Proof of the incapacity and dependency must be furnished to the Company by the Covered Student within 31 days after insurance would terminate because of age and as often as the Company may subsequently request but not more often than once a year after the 2 year period following the child's attainment of the limiting age.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends.

EXTENSION OF BENEFITS. If a Covered Person is confined to a Hospital on the date his or her coverage terminates, benefits will be payable for the Eligible Expenses incurred during the continuation of that Hospital Confinement. Such benefits will be payable until the earliest of: (1) the date the Hospital Confinement ends; (2) the end of the 90 day period following the date his or her coverage terminated; or (3) the date the applicable Maximum Amount is reached.

The Extension of Benefits will apply only to the extent the Covered Person will not be covered under the Policy or any other health insurance policy in the ensuing term of coverage.

CONTINUATION OF COVERAGE. If the Covered Student becomes ineligible under the Policy, he or she may continue coverage for up to an additional 6 months up to a maximum of $7,000. In no event, however, will the maximum amount of continued coverage exceed the difference between the Basic Aggregate Maximum Benefit amount shown in the Schedule of Benefits and the amount paid for the Eligible Expenses incurred by the Covered Person prior to ineligibility. Written request for continued coverage and payment of premium must be made within 31 days of the date the Covered Student became ineligible under the Policy. Continuation of coverage will be subject to all of the terms of the Policy.

Continuation of coverage will not be available to:

(a) a Dependent who is covered under any Policy of benefits for hospital, surgical or medical care and services provided by an employer or group; or
(b) any Covered Person who ceases to be eligible due to termination of the Policy.
(c) Any Covered Person who has met the Basic Aggregate Maximum Benefit Amount under the Policy.

CERTIFICATES OF CREDITABLE COVERAGE. The Company will issue Certificates of Creditable Coverage for each Covered Person whose coverage under this Policy is terminated. In addition, Certificates shall be issued when requested by a Covered Person, so long as such request is made within 24 months after cessation of coverage under the Policy. Such issuance will occur within a reasonable time.

SECTION 5 - GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES. This Policy, the Application and any attached papers make up the entire contract between the Policyholder and the Company. In the absence of fraud or intentional misrepresentation of a material fact, all statements made by the Policyholder or any Covered Person will be deemed representations and not warranties. No written statement made by a Covered Person will be used in any contest unless a copy of the instrument containing the statement is furnished to the Covered Person or his or her beneficiary or personal representative.

No change in this Policy shall be valid unless approved by an executive officer of the Company. The approval must be noted on or attached to this Policy. No agent has authority to change this Policy or to waive any of its provisions.

INCONTESTABILITY. The validity of this Policy will not be contested after it has been in force for two year(s) from the Policy Effective Date, except as to nonpayment of premiums.

PREMIUMS. The Company sets the premiums that apply to the coverage provided under this Policy. Those premiums are shown in a notice given to the Policyholder with or prior to delivery of this Policy. The Company has the right to adjust the premium rate when the terms of this Policy are changed. The Policyholder will be given notice in writing of such premium adjustment at least 60 days before the date it is to take effect unless due to a change in Policy terms that is to take effect before the 60 days.

RENEWAL OF POLICY. This Policy is issued for the Policy Term shown in the Schedule of Benefits. If the Policyholder wishes to continue coverage, the Company will issue a new Policy for a new Policy Term, subject to the then current underwriting requirements.

NOTICE OF CLAIM. Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to the Company at AIG, Educational Markets Mail Center, P.O. Box 26050, Overland Park, KS 66225, with information sufficient to identify the Covered Person, shall be deemed notice to the Company.

CLAIM FORMS. Upon receipt of a written notice of claim, the Company will give the claimant such forms as are usually given by the Company for filing proofs of loss. If such forms are not given within 15 days after the receipt of such notice, the claimant can fulfill the terms of this Policy as to proof of loss by giving written proof of: (a) the occurrence of the loss; and (b) the nature of the loss; and (c) the extent of the loss.

PROOFS OF LOSS. Written proof of loss must be given to the Company within 90 days after the date of such loss. Failure to give such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time. However, proof must be given as soon as reasonably possible.

TIME OF PAYMENT OF CLAIMS. The Company will pay or deny each clean claim as follows:

(a) if the claim is filed electronically, within 30 days after the date the claim is received by the Company.
(b) if the claim is filed on paper, within forty-five (45) days after the date the claim is received by the Company.

If the Company is unable to determine liability for or refuses to pay a claim of a provider within the times specified above, the Company will make a good-faith effort to notify the provider by fax, electronic or other written communication not more than:

(a) thirty (30) days of receipt of claim that is filed electronically; or
(b) forty-five (45) days of receipt of claim that is filed on paper;

and describe all specific reasons why it is not liable for the claim or that specific information is required to determine liability for the claim.

The Company will be subject to an interest penalty on this Policy's liability at the rate of one and one-half percent per month on:

(a) the amount of a clean claim filed electronically by the provider and not paid within thirty days of the date of receipt; and
(b) the amount of a clean claim filed on paper by the provider and not paid within forty-five days of the date of receipt.

"Clean claim" means a claim submitted, electronically or on paper, by a provider that:

(a) contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of the Policy;
(b) is not materially deficient or improper, including lacking substantiating documentation currently required under the Policy; or
(c) has no particular or unusual circumstances requiring special treatment that prevent payment from being made under the Policy within the times specified above.

PAYMENT OF CLAIMS. Benefits payable for covered health care Eligible Expenses incurred by a Covered Person are payable directly to the provider. If any such Eligible Expenses have been paid by the Covered Person, the benefit for those Eligible Expenses will be paid to the Covered Student. If the Covered Student dies, the Company will pay any accrued benefits at the time of death to the beneficiary or, if no beneficiary is designated and surviving the Covered Student, then as follows: (a) the Covered Student's Spouse; (b) children; (c) parents; (d) brothers or sisters; or (e) legal guardian, if a minor; (f) otherwise to the Covered Student's estate.

If any payee is a minor or is not competent to give a valid release for the payment, the payment will be made to the legal guardian of the payee's property. If the payee has no legal guardian for his or her property, a payment not exceeding $1,000 may be made, at the Company's option, to any relative by blood or connection by marriage of the payee, who, in the Company's opinion, has assumed the custody and support of the minor or responsibility for the incompetent person's affairs.

In the event that the New Mexico Human Services Department has made payment for services claimed under this Policy and the Company is notified that the Covered Person received benefits under the Medicaid Program, the payment made for those services under this Policy will be made to the applicable New Mexico Human Services Department.

If a healthcare provider provides service or treatment to a Covered Person who is also eligible for benefits under the Medicaid Program, the Company may pay the healthcare provider directly if notice of the Covered Person's eligibility for Medicaid benefits is attached to the claim for benefits under this Policy.

Any payment the Company makes in good faith fully discharges the Company's liability to the extent of the payment made.

SECTION 5 - GENERAL PROVISIONS

ASSIGNMENT. This Policy is non-assignable.

PHYSICAL EXAMINATION AND AUTOPSY. The Company at its own expense has the right to have a Doctor examine a Covered Person when and so often as it deems reasonably necessary while there is a claim pending under this Policy and to make an autopsy in case of death where it is not forbidden by law.

LEGAL ACTIONS. No action at law or in equity shall be brought to recover on this Policy within 60 days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action shall be brought after the expiration of three years from the time that proof of loss was required to be furnished.

RECORDS MAINTAINED. The Policyholder or its authorized representative shall maintain records of each person covered. The records shall show all data that is needed to administer this Policy.

EXAMINATION AND AUDIT. The Company shall be allowed to examine and audit the Policyholder's books and records which pertain to this Policy at reasonable times. The Company must also be allowed to do this within 3 years after the later of: (a) the date this Policy terminates; or (b) until final settlement of all claims hereunder.

CONFORMITY WITH STATE STATUTES. Any provision of this Policy which, on its effective date, is in conflict with the statutes of the state in which this Policy is delivered is hereby amended to conform to the minimum requirements of such statutes.

POLICY ERROR. Clerical errors, whether by the Policyholder or the Company, will not void the insurance of any Covered Person if that insurance would otherwise have been in effect nor extend the insurance of any Covered Person if that insurance would otherwise have ended or been reduced as provided in the Policy.

NOT IN LIEU OF WORKERS' COMPENSATION. This Policy is not a Workers' Compensation policy. It does not provide Workers' Compensation benefits.

RIGHT OF RECOVERY. As a condition to receiving benefits under this Policy, the Covered Person (or, if he or she is deceased, an authorized representative of the Covered Person) agrees, except as may be limited or prohibited by applicable law:

(a) to reimburse the Company for any such benefits paid to or on behalf of the Covered Person, if such benefits are recovered, in any form, from any Third Party or Coverage; and

(b) if the Covered Person is a minor or is not competent to make this agreement, the legal guardian of the Covered Person's property makes the agreement on the Covered Person's behalf as a condition to receiving benefits under this Policy on behalf of the Covered Person. If the Covered Person has no guardian for his or her property, the person or persons who, in the Company's opinion, have assumed the custody and support of the minor or responsibility for the incompetent person's affairs make the agreement on the Covered Person's behalf as a condition to receiving such benefits under the Policy on behalf of the Covered Person.

SUBROGATION. In the event any payments for benefits provided to a Covered Person are because of an Injury or Sickness caused by a Third Party's wrongful act or negligence, the Company, to the extent of that payment, will be subrogated to any recovery or right of recovery the Covered Person has against that Third Party, provided:

(a) the Covered Person is entitled to payment for Hospital, surgical or medical services as the result of a Third Party settlement or court judgment; and

(b) such settlement or judgment specified an amount or portion of payment that represents payment for such benefits; and

(c) the Company has paid benefits to the Covered Person under this Policy for the same services or benefits covered by the settlement or judgment.

The Covered Person agrees to make a decision on pursuing a claim against a Third Party within 30 days of the date the Company requires that the Covered Person provide Notice of Claim for the Injury or Sickness for which benefits under this Policy are sought and to notify the Company of his or her decision within such 30 day period.

In the event the Covered Person decides not to pursue payment of claim against such Third Party, the Covered Person:
(a) authorizes the Company to pursue, sue, compromise or settle any such payment of claim in the name of the Covered Person;
(b) authorizes the Company to execute any and all documents necessary; and
(c) agrees to cooperate fully with the Company in the prosecution of any such payment of claim.

If the Company exercises its rights under this provision, it will recover no more than the amount paid under this Policy for such benefits. The Covered Person will execute and deliver such instruments and papers which may be needed to secure the rights described above.

The Company will not pay or be responsible, without its written consent, for any fees or costs associated with the pursuit of a claim, cause of action or right by or on behalf of a Covered Person against any Third Party or coverage.

"Subrogation" means the Company's right to recover any benefit payments made under this plan:
(a) because of an Injury or Sickness to a Covered Person caused by a Third Party's wrongful act or negligence; and
(b) which become recoverable from the Third Party or the Third party's insurer.

The Company's right of subrogation will not be enforced until the Covered Person has been made whole, as determined by a court of law, as a result of injury or Sickness.

"Third Party" means any person or organization other than the Company, the Policyholder or the Covered Person.

This provision will not apply if it is prohibited by law.

EXCESS PROVISION

Benefits payable for the Eligible Expenses under this provision will be limited to that part of the Eligible Expense, if any, which is in excess of the total benefits payable for the same Injury or Sickness, on a provision of service basis or on an expense incurred basis under any Other Valid and Collectible Insurance. If the Other Valid and Collectible Insurance provides benefits on an excess coverage basis (other than Medicaid or Tricare), benefits will be coordinated with the Other Valid and Collectible Insurance to allow 50% of any Eligible Expense up to the Policy Maximum.

Benefits paid by the Policy will not exceed:
(a) any applicable Policy Maximums; and
(b) 100% of the compensable expense incurred when combined with benefits paid by any Other Valid and Collectible Insurance.

SECTION 5 - GENERAL PROVISIONS

For purposes of this Policy, a Covered Person's entitlement to Other Valid and Collectible Insurance will be determined as if this Policy did not exist and will not depend on whether timely application for benefits from Other Valid and Collectible Insurance is made by or on behalf of the Covered Person.

Benefits under this Policy will be reduced to the extent that benefits for Expenses are covered by any Other Valid and Collectible Insurance whether or not a claim is made for such benefits.

SECTION 6 - COVERAGE DESCRIPTIONS

All coverages of this Policy are shown in the Schedule of Benefits. The coverages are described and governed by the pages attached to and made a part of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

When, by reason of Injury or Sickness, a Covered Person incurs Eligible Expenses covered by the Accident and Sickness Expense Benefit Provisions which follow, the Company will pay for the Eligible Expense incurred in excess of the Deductible Amount. Benefits are paid in accordance with the allocations shown for the Accident and Sickness Expense Benefits in the Schedule of Benefits. The Company will not pay more than the applicable Aggregate Maximum Amount as a result of any one Accident or One Sickness. The first such Expense must be incurred within 30 days after the date of the Accident causing the Injury or from the first medical treatment for the Sickness.

The Basic Aggregate Maximum Benefit and Deductible Amount are shown in the Schedule of Benefits.

Expenses for Elective Treatment or elective surgery will not be covered except as specifically provided elsewhere in this Policy.

If benefits under this coverage are payable under more than one provision under this Policy, then benefits will be provided only under the provision providing the greater benefit.

This provision is subject to all the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

HOSPITAL EXPENSE

Hospital Expenses will be paid as follows:

Part A. Hospital Room and Board Expense - When, by reason of Injury or Sickness, a Covered Person requires Hospital Confinement, the Company will pay the Covered Percentage of the Hospital room and board expense incurred for the period of such confinement. However, the covered room and board expense does not include any charge in excess of the Daily Room and Board Maximum.

Part B. Miscellaneous Hospital Expense - "Miscellaneous Hospital Expense" includes expenses incurred for anesthesia and operating room; laboratory tests and X-rays; oxygen tent; drugs, (excluding take-home drugs) medicines, dressings; and other Medically Necessary and prescribed Hospital Expenses.

The Company will pay the Covered Percentage of the Miscellaneous Hospital Expense incurred by the Covered Person during the period of Hospital Confinement for which benefits are payable under Part A above.

BENEFITS FOR MATERNITY

When a Covered Person is confined to a Hospital as a resident inpatient for childbirth, the Company will pay benefits in the same manner and subject to the same conditions and limitations as any other Sickness, but, in no event, will benefits be less than:

(a) 48 hours after a non-cesarean delivery; or
(b) 96 hours after a cesarean section;

for the mother and the newborn infant(s), unless, at the mother's option, an earlier discharge occurs. Such coverage for maternity care shall include the services of a certified nurse-midwife under qualified medical direction. The Company will not pay for duplicative routine services actually provided by both a certified nurse-midwife and a Doctor.

In the event such earlier discharge occurs, at least one home visit will be available to the mother.

The first home visit, (which may be requested at any time within 48 hours of the time of delivery, or within 96 hours in the case of a cesarean section) will be conducted within 24 hours following:

(a) discharge from the Hospital; or
(b) the mother's request; whichever is later.

Benefits include:

(a) parent education;
(b) assistance and training in breast or bottle feeding; and
(c) the performance of any necessary maternal and newborn clinical assessments.

The Daily Room and Board Maximum and Covered Percentage are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

SURGICAL EXPENSE

Surgical Expense will be paid as follows:

Part A. When, by reason of Injury or Sickness, a Covered Person requires surgery on an inpatient or outpatient basis, the Company will pay the Covered Percentage of the Eligible Expense incurred in connection with such surgery. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

DEFINITIONS

"Surgical Expense" means charges by a Doctor for:

(a) a surgical procedure;
(b) a necessary preoperative treatment during a Hospital stay in connection with such procedure; and
(c) usual postoperative treatment.

"Surgical procedure" means:

(a) a cutting procedure;
(b) suturing of a wound;
(c) treatment of a fracture;
(d) reduction of a dislocation;
(e) radiotherapy (excluding radioactive isotope therapy), if used in lieu of a cutting operation for removal of a tumor;
(f) electrocauterization;
(g) diagnostic and therapeutic endoscopic procedures;
(h) injection treatment of hemorrhoids and varicose veins;
(i) an operation by means of laser beam;
(j) casting;
(k) removal of a foreign body;
(l) drainage or aspiration;
(m) implant;
(n) catheter placement;
(o) microsurgery.

BENEFITS

The benefit will be equal to the amount determined by multiplying the Eligible Expenses incurred by the Covered Percentage shown in the Schedule of Benefits. When Injury or Sickness requires multiple surgical procedures, the Company will pay a benefit for each procedure.

Part B. If, in connection with such surgery, the Covered Person requires the services of an anesthetist, who is not employed or retained by the Hospital in which the surgery is performed, the Company will pay the Covered Percentage of the Eligible Expense incurred.

Part C. If, in connection with such surgery, the Covered Person requires the services of an Assistant Surgeon, the Covered Percentage of the Eligible Expense incurred.

The applicable Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

IN-HOSPITAL DOCTOR'S FEES EXPENSE

When, by reason of Injury or Sickness, a Covered Person is confined to a Hospital and requires the services of a Doctor other than a Doctor who performed surgery on, or administered anesthesia to, the Covered Person, the Company will pay the Covered Percentage of the Eligible Expense incurred for such services. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The applicable Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

OUTPATIENT EXPENSE

If, by reason of Injury or Sickness, a Covered Person requires the use of the services listed in the Schedule of Benefits for this coverage, the Company will pay the Covered Percentage of the Eligible Expenses incurred. The Company will not pay more than any applicable Maximum Benefit shown in the Schedule of Benefits in any Policy Year. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The Covered Percentage and applicable Maximum Amounts are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

OUT OF HOSPITAL DOCTOR'S FEES EXPENSE

Subject to the Exception below:

If, by reason of Injury or Sickness, a Covered Person requires the services of a Doctor while not confined as a resident bed-patient in a Hospital, the Company will pay the Covered Percentage of the Eligible Expenses incurred subject to the Maximum Number of Visits per Day. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The applicable Covered Percentage and Maximum Number of Visits per Day are shown in the Schedule of Benefits.

EXCEPTION

If the services are in connection with surgery and the Doctor is the surgeon who performed the surgery, no benefits are payable under this provision outside of the Student Health Center.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

CONSULTANT'S FEES EXPENSE

If a Covered Person, as a result of an Injury or a Sickness, requires the services of a Consultant, the Company will pay the Covered Percentage of the Eligible Expense incurred for such services. Such service must be requested and ordered by the attending Doctor. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The applicable Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

AMBULANCE EXPENSE

When, by reason of Injury or Sickness, a Covered Person requires the use of a professional ambulance in an emergency, the Company will pay the Covered Percentage of the Eligible Expenses incurred. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

“Ambulance” means a vehicle licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for Covered Persons who are unable to travel to receive medical care by any other means or the Hospital cannot provide the needed care.

The applicable Covered Percentage is shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

DENTAL EXPENSE

If a Covered Person incurs Eligible Expenses for services of a legally qualified dentist or dental surgeon for treatment made necessary by Injury to Sound Natural Teeth, the Company will pay the Covered Percentage of the Eligible Expenses up to the Maximum Amount per Tooth. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The Covered Percentage and Maximum Amount per Tooth are shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

OPTIONAL DENTAL TREATMENT EXPENSE

Dental Expense will be paid as follows:

When a Covered Person incurs Eligible Dental Expenses for basic services, preventive services or major services dental treatment during the Policy Year that are in excess of the Optional Dental Treatment Deductible Amount, the Company will pay the Covered Percentage of the Eligible Dental Expense incurred in connection with covered dental treatment based on the Schedule of Covered Dental Charges below. The Eligible Dental Expenses must be incurred while the Covered Person is insured for these benefits.

DEFINITIONS

"Eligible Dental Expense" means charges by a dentist, other Doctor or dental hygienist acting within the scope of such person's license that is:

(a) a dental procedure listed in the Schedule of Covered Dental Charges;
(b) customarily used for treatment of the dental condition; and
(c) done according to accepted standards of dental practice.

BENEFITS

The benefit will be equal to the amount determined by multiplying the Eligible Dental Expenses incurred in excess of the Optional Dental Treatment Deductible Amount by the Covered Percentage for this coverage, subject to the Maximum Amount per Policy Year shown, in the Schedule of Benefits,

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

OPTIONAL DENTAL TREATMENT EXPENSE (continued)

SCHEDULE OF COVERED DENTAL SERVICES

PREVENTIVE SERVICES **Covered Percentage**	**100%**
Preventive Service	
Oral Exam – limited to 2 per Policy Year	
Emergency PalliativeTreatment	
Panorex film – limited to 1 procedure per 36 month period	
Full mouth x-ray – limited to 1 procedure per 36 month period	
Periapical x-ray	
Additional Periapical – 18 or more at one sitting will be considered a full mouth	
Bitewing – limited to 1 procedure per 6 month period	
Biopsy of Oral Tissue	
Prophy – Adult – limited to 1 procedure per 6 month period	
Prophy – Child – limited to 1 procedure per 6 month period	
Fluoride – under age 19 limited to 1 procedure per Policy Year	
Pulp Vital Tests – limited to 1 per Policy Year	
Fissure sealants on unfilled permanent molars – limited to 1 per tooth for a Dependent child under age 19	
Space Maintainers – available only to a Covered Person under the age of 19	
BASIC SERVICES **Covered Percentage**	**80%**
Simple Restorative Fillings	
One surface amalgam – primary	
Two surface amalgam – primary	
Three surface amalgam – primary	
Four surface amalgam – primary	
One surface amalgam – permanent	
Two surface amalgam – permanent	
Three surface amalgam – permanent	
Four surface amalgam – permanent	
Composite Fillings (anterior teeth only)	
Oral Surgery	
Simple extraction	
Additional extraction	
Surgical extraction	
Impacted (soft tissue)	
Uncomplicated extraction of erupted teeth	
Root Canal Therapy, with X-rays and cultures – anterior teeth and bicuspids	
Stainless Steel Crowns	
Scaling and root planing	

OPTIONAL DENTAL TREATMENT EXPENSE (continued)

SCHEDULE OF COVERED DENTAL SERVICES (continued)

MAJOR SERVICES **Covered Percentage**	**50%**
Composite Fillings (other than anterior teeth)	
Endodontics (other than Root Canal Therapy shown above)	
Periodontics (other than scaling and root planing shown above)	
Oral Surgery*	
Impacted (partial bony)	
Impacted (complete bony)	
Oral surgery (other than uncomplicated extraction of erupted teeth shown above)	
Root Canal Therapy with X-rays and cultures – molars	
General Anesthesia	
Inlays, onlays, crowns	
Pontics	
Full or partial dentures by a Denturist	
Anesthesia other than general anesthesia	
Repair of dentures by Denturist	
***Osseous surgery available only to a Covered Person under the age of 19	

PRESCRIBED MEDICINES EXPENSE

If, by reason of Injury or Sickness, a Covered Person requires medicines, the Company will pay the Covered Percentage of the Eligible Expense incurred by the Covered Person for such medicines. The medicines must be prescribed by the Student Health Center or attending Doctor. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

Eligible Expenses will include charges for any drug approved by the United States Food and Drug Administration whether or not used for the treatment of a particular indication for which the drug has been prescribed, provided the drug is recognized as safe and effective for treatment of that indication in one or more of the standard medical reference compendia, including AMA Drug Evaluations, the American Hospital Formulary Service Drug Information and Drug Information for the Healthcare Provider. Coverage of such drugs includes the Medically Necessary services associated with the administration of the drug provided such services would not be otherwise excluded from coverage.

Eligible Expenses do not include drugs labeled "Caution - limited by Federal Law to investigational use", or any experimental drugs, even though a charge is made.

Prescription Drugs and Devices for Birth Control

Benefits are payable for Eligible Expenses incurred for prescription contraceptive drugs and devices that are approved by the federal Food and Drug Administration (FDA). The Company will pay benefits for the Eligible Expense incurred as shown in the Schedule of Benefits.

Coverage of Prescription Eye Drop Refills

If coverage of prescription eye drops is provided under this Policy, refills of eye drop medication requiring a prescription will be covered in the following manner: (a) the refill is requested by the Covered Person at least 23 days for a 30-day supply of eye drops, 45 days for a 60-day supply of eye drops, 68 days for a 90-day supply of eye drops, from the later of the date that the original prescription was dispensed to the Covered Person or the date that the last refill of the prescription was dispensed to the Covered Person; (b) the prescriber indicates on the original prescription that additional quantities are needed and that the refill requested by the Covered Person does not exceed the number of additional quantities needed.

“Prescriber” means a person who is authorized pursuant to the New Mexico Drug, Device and Cosmetic to prescribe prescription eye drops.

Oral Anticancer Medication Coverage

Benefits will be payable 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. A medication provided under this provision will be prescribed only upon finding that it is Medically Necessary by the treating Doctor for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the Covered Person, Doctor or other health care provider. The Covered Person has the option of having such medication dispensed at any appropriately licensed pharmacy.

PRESCRIBED MEDICINES EXPENSE (Continued)

The Company will not pay more than the Prescribed Medicines Expense Maximum shown in the Schedule of Benefits per Policy Year.

For purposes of this coverage, prescription medicine means a drug or medicine which may be obtained only on a Doctor's written prescription.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

ABORTION EXPENSE

If, as a result of pregnancy having its inception during the Policy Year covered by this Policy, a Covered Person has a voluntary abortion, the Company will pay the Covered Percentage of the Eligible Expense incurred. The Eligible Expenses must be incurred while the covered Person is insured for these benefits.

The Covered Percentage is shown in the Schedule of Benefits.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

MENTAL AND NERVOUS DISORDERS EXPENSE

When a Covered Person requires treatment for a Mental or Nervous Disorder, the Company will pay for benefits for such treatment. The Eligible Expenses must be incurred while the covered Person is insured for these benefits.

BENEFITS FOR HOSPITAL CONFINEMENT

When the Covered Person requires Hospital Confinement for treatment of a Mental or Nervous Disorder, the Company will pay the Eligible Expense for such confinement on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

BENEFITS FOR OUTPATIENT SERVICES

When the Covered Person is not Hospital confined, the Company will pay for each session of Eligible Expenses for Outpatient Services, prescription drugs and diagnostic testing, on the same basis as any other Sickness.

Definitions:

"Covered Outpatient Services for the Treatment of Mental and Nervous Conditions" means the services furnished by the following:

(a) a comprehensive health care service organization;
(b) a Hospital;
(c) by a facility approved by the State Department of Mental Health which is:
- a community mental health center; or
- any other mental health clinic; or
- an independent clinical social worker; or
- a clinical specialist in psychiatric and mental health nursing.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

INSURANCE PROVISIONS CONCERNING
ACCIDENT and SICKNESS EXPENSE BENEFITS

ALCOHOLISM AND SUBSTANCE ABUSE EXPENSE

If, by reason of alcoholism or alcohol abuse, substance abuse or substance dependency, a Covered Person requires treatment, the Company will pay benefits for the inpatient or outpatient Eligible Expenses incurred at a Hospital or Outpatient Facility for the Medically Necessary treatments on the same basis as any other Sickness. The Eligible Expenses must be incurred while the covered Person is insured for these benefits.

No benefits will be paid for the Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

OPTIONAL VISION CARE EXPENSE

If a Covered Person incurs Eligible Expenses for vision care services that are received while insured under this Policy, and is performed or prescribed by an optometrist or other Doctor, the Company will pay the Covered Percentage of the Eligible Expense in excess of the applicable Deductible, subject to the Maximum Amount shown for this coverage in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

Eligible Expenses include the following:

(a) charges made for vision examination by an optometrist or ophthalmologist, including:
- (1) an external or an opthalmoscopic exam;
- (2) an ocular case history;
- (3) a refraction;
- (4) a binocular measure;
- (5) tonometry;
- (6) any other vision test that is Medically Necessary;
- (7) a summary and findings of the exam; or
- (8) a prescription for any needed corrective lenses, and inspection of those lenses.

But, the Company will not pay for an examination more than once every 12 months.

(b) charges made for lenses. But, the Company will not pay for more than one pair of lenses every 12 months.

(c) charges incurred for frames. But, the Company will not pay for more than one frame every 24 months.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

DIABETES EXPENSE

If, by reason of Sickness, a Covered Person incurs Eligible Expenses for the following equipment and supplies for the treatment of: (1) insulin-using diabetes; (2) non-insulin using diabetes; and (3) elevated blood glucose levels induced by pregnancy, the Company will pay benefits for the Eligible Expenses incurred on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. Such equipment and supplies must be recommended in writing or prescribed by a Doctor. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The Eligible Expenses include but are not limited to the following equipment and supplies:

(a) lancets and lancet devices;
(b) test strips for blood glucose monitors;
(c) visual reading urine and ketone strips;
(d) blood glucose monitors, including those for the legally blind;
(e) insulin;
(f) injection aids including those adaptable to meet the needs of the legally blind;
(g) syringes;
(h) prescriptive oral agents for controlling blood sugar levels;
(i) glucagon emergency kits; and
(j) Medically Necessary podiatric appliances for the prevention of feet complications associated with diabetes, including therapeutic molded or depth-inlay shoes, functional orthotics, custom molded inserts, replacement inserts, preventive devices and shoe modifications for prevention and treatment.

Coverage is also provided for Medically Necessary diabetes self-management training provided by a certified, registered or licensed health care professional with recent education in diabetes management and will be limited to:

(a) Medically Necessary visits following a Doctor's diagnosis of diabetes;
(b) visits following a Doctor's diagnosis that represents a significant change in the Covered Person's symptoms or condition that warrants changes in the Covered Person's self-management; and
(c) visits when re-education or refresher training is prescribed by a health care practitioner with prescribing authority; and
(d) medical nutrition therapy related diabetes management.

In addition, Eligible Expenses will include, and on the approval of the United States Food and Drug Administration, new or improved diabetes equipment or diabetes supplies, including improved insulin or other prescription drugs, coverage of new or improved equipment or supplies if Medically Necessary and appropriate for the treatment of diabetes as determined by a Doctor or other health care practitioner.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

SMOKING CESSATION TREATMENT

Benefits are payable for Eligible Expenses incurred for smoking cessation treatment. The Company will pay the Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

CHILDHOOD IMMUNIZATION EXPENSE

Benefits are payable for Eligible Expenses incurred for immunizations of a covered Dependent child, as well as Medically Necessary booster doses of all immunizing agents used in child immunizations, in accordance with the current schedule of immunizations recommended by the American Academy of Pediatrics. The Eligible Expenses must be incurred while the covered Dependent child is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

MAMMOGRAPHY AND CYTOLOGICAL SCREENING EXPENSE

Benefits are payable for Eligible Expenses incurred by a Covered Person for: (a) cytologic and human papillomavirus screening performed by a health care provider for determining the presence of precancerous or cancerous conditions and other health problems; and (b) low-dose screening mammograms for determining the presence of breast cancer. The charges must be incurred while a Covered Person is insured for these benefits.

Benefits will be paid for Eligible Expenses incurred on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

Eligible Expenses include the following:

(a) in the case of benefits for cytologic screening, as determined by the Doctor in accordance with national medical standards:
  (1) for women (18) eighteen years of age and older; and
  (2) for women who are at risk of cancer or at risk of other health conditions that can be identified through cytologic screening.

(b) in the case of benefits for human papillomavirus screening and vaccine:
  (3) human papillomavirus screening for women once every three years for women age 30 and older; and
  (4) the administration of the human papillomavirus vaccine, for females 9 to 14 years of age, that is approved by the federal Food and Drug Administration.

  In addition, coverage shall be provided for the following cervical cytology screening services, and such coverage shall be subject to the following and in accordance with the benefits for Preventive Services mandated by the Patient Protection and Affordable Care Act shown in the Schedule of Benefits:
  (i) evidence-based items or services for cervical cytology that have in effect a rating of “A” or “B” in the current recommendations of the United States preventive services task force; and
  (ii) with respect to a female Covered Person, such additional preventive care and screenings for cervical cytology not described in item (i) above and as provided for in comprehensive guidelines supported by the health resources and services administration.

  “Cytologic screening” means a Papanicolaou test and a pelvic exam for asymptomatic as well as symptomatic women.

  “Human papillomavirus screening” means a test approved by the Federal Food and Drug Administration for detection of the human papillomavirus.

  “Health care provider” means any person licensed within the scope of his or her practice to perform cytologic and human papillomavirus screening, including Doctors, Doctors’ assistants, certified nurse midwives and certified nurse practitioners.

(b) In the case of mammograms:
  (1) one baseline mammogram for persons age 35 through 39.
  (2) one mammogram biennially for persons age 40 through 49.
  (3) one mammogram annually for persons age 50 and over.

MAMMOGRAPHY AND CYTOLOGICAL SCREENING EXPENSE (continued)

In addition, coverage shall be provided for the following mammography screening services, and such coverage shall be subject to the following and in accordance with the benefits for Preventive Services shown in the Schedule of Benefits:

(i) evidence-based items or services for mammography that have in effect a rating of “A” or “B” in the current recommendations of the United States preventive services task force; and

(ii) with respect to a female Covered Person, such additional preventive care and screenings for mammography not described in item (i) above and as provided for in comprehensive guidelines supported by the health resources and services administration.

Benefits shall be available only for screening mammograms obtained on equipment designed specifically to perform low-dose mammography in imaging facilities that have met American College of Radiology accreditation standards for mammography.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

COLORECTAL CANCER SCREENING EXPENSE

Benefits are payable for Eligible Expenses incurred for colorectal cancer screening for determining the presence of precancerous or cancerous conditions and other health problems. Eligible Expenses include such screening, as determined by the Doctor, in accordance with the evidence-based recommendations established by the United States Preventive Services Task Force. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

RECONSTRUCTIVE BREAST SURGERY

Benefits are payable for Eligible Expenses incurred for breast reconstructive surgery after a mastectomy. This provision includes coverage for:

(a) all stages of reconstruction of the breast on which the mastectomy has been performed;
(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
(c) prostheses and physical complications at all stages of mastectomy**,** including lymphedemas.

Benefits provided under this provision will be paid on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while a Covered Person is insured for these benefits.

“Mastectomy” means the removal of all or part of the breast for Medically Necessary reasons, as determined by the Doctor.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

PROSTATE CANCER SCREENING

Benefits are payable for Eligible Expenses incurred by a male Covered Person who is 50 years old or older for prostate cancer screening, commonly known as a prostate specific antigen (PSA) test. The Company will pay the Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This Provision is subject to all of the terms of the Policy.

TMJ EXPENSE

Benefits are payable for Eligible Expenses incurred for Medically Necessary diagnostic and surgical treatment of temporomandibular joint disorders (TMJ) and craniomandibular joint disorders as a result of:

(a) a trauma;
(b) a congenital defect;
(c) a developmental defect; or
(d) a pathology.

Coverage under this Policy for such diagnostic and surgical services will be on the same basis as that for any other joint in the body. The treatment must be administered or supervised by a Doctor.

Orthodontic appliances and treatment, crowns, bridges and dentures will not be considered Eligible Expenses under this provision unless such is made necessary by trauma.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

HEARING AID EXPENSE

Benefits are payable for Eligible Expenses for a hearing aid and any related service for the full cost of one hearing aid per hearing-impaired ear up to two thousand two hundred dollars ($2,200) every thirty-six (36) months for hearing aids for a covered Dependent child under eighteen (18) years of age or under twenty-one (21) years of age if still attending high school. The Covered Person may choose a higher priced hearing aid and may pay the difference in cost above the two-thousand-two-hundred-dollar ($2,200) limit without financial or contractual penalty to the Covered Person or to the provider of the hearing aid.

"Hearing aid " means durable medical equipment that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children.

Hearing aid coverage shall include fitting and dispensing services, including providing ear molds as necessary to maintain optimal fit, provided by an audiologist, a hearing aid dispenser or a licensed Doctor.

The Company will pay the Eligible Expenses on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

TREATMENT OF INBORN ERRORS OF METABOLISM EXPENSE

Benefits are payable for Eligible Expenses for the treatment of genetic inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist. Eligible Expenses include diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis, medical supplies, prescription drugs, corrective lenses for conditions related to the genetic inborn error of metabolism, nutritional management and special medical foods used in treatment to compensate of the metabolic abnormality and to maintain adequate nutritional status.

“Genetic inborn error of metabolism” means a rare, inherited disorder that: (a) is present at birth; (b) if untreated, results in mental retardation or death; and (c) causes the necessity for consumption of special medical foods.

“Special medical foods” means nutritional substances in any form that are: (a) formulated to be consumed or administered internally under the supervision of a Doctor; (b) specifically processed or formulated to be distinct in one or more nutrients present in natural food; (c) intended for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained in ordinary foodstuffs or who have other specific nutrient requirement as established by medical evaluation; and (d) essential to optimize growth, health and metabolic homeostasis.

“Treatment” means medical services provided by a Doctor or other licensed health care professional, including dieticians and nutritionists with specific training in managing patients diagnosed with genetic inborn errors of metabolism.

Benefits provided for this provision will be paid on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The charges must be incurred while a Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

EMERGENCY CARE EXPENSE

If a Preferred Provider Plan is available under this Policy and the Covered Person is insured for such coverage and he or she is unable to reasonably reach a Preferred Provider, the Company will pay the Eligible Expenses for the following emergency care services at the Preferred Provider benefit level:

(a) any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital which is necessary to determine whether a medical emergency condition exists;
(b) necessary emergency care services including treatment and stabilization of an Emergency Medical Condition; and
(c) services originating in a Hospital emergency facility following treatment or stabilization of an Emergency Medical Condition.

“Preferred Provider Plan” means a benefit plan through which the Company provides for the payment of a level of coverage that is different from the basic level of coverage provided under the Policy if the Covered Person uses a Preferred Provider.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

DENTAL ANESTHESIA EXPENSE

Benefits are payable for Eligible Expenses incurred by a Covered Person for general anesthesia and associated Hospital or ambulatory surgical facility charges in connection with dental surgery or other procedures for which hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits.

The Covered Person must be:

(a) an individual for whom a successful result cannot be expected from dental care provided under local anesthesia (with or without additional adjunctive techniques and modalities) because of a physical, intellectual or medically compromising condition;

(b) an individual for whom local anesthesia is ineffective because of acute infection, anatomic variation or allergy;

(c) an insured child or adolescent who is extremely uncooperative, fearful, anxious, or uncommunicative with dental needs of such magnitude that treatment should not be postponed or deferred and for whom lack of treatment can be expected to result in dental or oral pain or infection, loss of teeth or other increased oral or dental morbidity;

(d) an individual who has sustained extensive oral-facial or dental trauma; or

(e) an individual who requires some other procedures for which hospitalization or general anesthesia in a Hospital or ambulatory surgical center is Medically Necessary.

“General anesthesia” means the use of an anesthetic that is complete and affects the entire body, causing loss of consciousness when the anesthetic acts upon the brain.

Benefits provided under this provision will be paid on the same basis as any other Accident or Sickness according to the limits and maximums shown in the Schedule of Benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all the terms of this Policy.

MATERNITY TESTING EXPENSE

Benefits are payable for Eligible Expenses incurred by a Covered Person for routine maternity tests and screening exams. The Eligible Expenses must be incurred while the Covered Person is insured for these benefits. The Company will pay the benefit for the Eligible Expense on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits.

Benefits will be paid for Eligible Expenses incurred for the following tests:

(a) pregnancy tests;
(b) CBC;
(c) Hepatitis B Surface Antigen;
(d) Rubella Screen;
(e) Syphilis Screen;
(f) Chlamydia;
(g) HIV;
(h) Gonorrhea;
(i) Toxoplasmosis;
(j) Blood Typing ABO;
(k) RH Blood Antibody Screen;
(l) Urinalysis;
(m) Urine Bacterial Culture;
(n) Microbial Nucleic Acid Probe;
(o) Pap Smear; and
(p) Alpha-fetoprotein IV Screen (between sixteen and twenty weeks of pregnancy).

One ultrasound test may be administered per pregnancy without any additional diagnosis. Eligible Expenses for subsequent ultrasound tests may be payable if such additional tests are determined to be Medically Necessary.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

EARLY CHILDHOOD INTERVENTION SERVICES EXPENSE

The Company will pay the Covered Percentage of Eligible Expenses incurred in excess of the Deductible in connection with the family, infant, toddler program administered by the department of health, provided eligibility criteria are met, up to a maximum of three thousand five hundred dollars ($3,500) annually. Such coverage shall apply to the Covered Student's Dependent child from birth to three years of age. The services rendered must be Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in 7.30.8 NMAC who are working in early intervention programs approved by the department of health.

The benefits payable under this coverage shall not be applied to any maximum lifetime or annual limits specified in the Policy.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

CLINICAL TRIALS EXPENSE

Benefits are payable for routine patient care costs incurred by a Covered Person as a result of his or her participation in a cancer clinical trial if:

(a) the clinical is undertaken for the purposes of the prevention or reoccurrence of cancer, or the early detection or treatment of cancer for which no equally or more effective standard cancer treatment exists;

(b) the clinical trial is not designed exclusively to test toxicity or disease pathophysiology and it has therapeutic intent;

(c) the clinical trial is being provided in this state as part of a scientific study of a new therapy or intervention and is for the prevention or reoccurrence, early detection, treatment or palliation of cancer in humans and in which the scientific study includes all of the following:
  (1) specific goals;
  (2) a rationale and background for the study;
  (3) criteria for patient selection;
  (4) specific direction for administering the therapy or intervention and for monitoring patients;
  (5) a definition of quantitative measures for determining treatment response;
  (6) methods for documenting and treatment adverse reactions; and
  (7) a reasonable expectation that the treatment will be at least as efficacious as standard cancer treatment.

The clinical trial must be one conducted with the approval of at least one of the following entities:

(a) one of the federal national institutes of health;

(b) a federal national institutes of health cooperative group or center;

(c) the federal department of defense;

(d) the federal food and drug administration in the form of an investigational new drug application;

(e) the federal department of veterans affairs; or

(f) a qualified research entity that meets the criteria established by the federal national institutes of health for grant eligibility.

Any clinical trial receiving benefits under this coverage must meet the following requirements:

(a) the trial provided as part of a study being conducted in a phase II, phase III, or phase IV cancer clinical trial;

(b) the proposed trial or study has been reviewed and approved by an institutional review board that has an active federal-wide assurance of protection for human subjects must have therapeutic intent;

(c) the personnel providing the clinical trial or conducting the study are providing such within their scope of practice, experience and training and are capable of providing the clinical trial because of their experience, training and volume of patients treated to maintain their expertise;

(d) agree to accept reimbursement as payment in full from the health plan at the rates that are established by the plan;

(e) agree to provide written notification when the Covered Person enters or leaves a clinical trial;

(f) there is no non-investigational treatment equivalent to the clinical trial; and

(g) the available clinical or preclinical data provide a reasonable expectation that the clinical trial will be at least as efficacious as any non-investigational alternative the principal purpose of the trial is to test whether the intervention potentially improves the participant's health outcomes;

(h) there is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial will be at least as effective as any other medical treatment.

CLINICAL TRIALS EXPENSE (continued)

"Routine patient care cost" means: (a) a medical service or treatment that is a benefit under the Policy that would be covered if the patient were receiving standard cancer treatment; or (b) a drug provided to a patient during a cancer clinical trial if the drug has been approved by the food and drug administration, whether or not that organization has approved the drug for use in treating the patient's particular condition, but only to the extent that the drug is not paid for by the manufacturer, distributor or provider of the drug.

It does NOT include: (a) the cost of an investigational drug, device or procedure; (b) the cost of a non-health care service that the patient is required to receive as a result of participation in the cancer clinical trial; (c) costs associated with managing the research that is associated with the cancer clinical trial; (d) costs that would not be covered under the Policy if non-investigational treatments were provided; (e) costs of those extra tests that would not be performed except for participation in the cancer clinical trial; and (f) costs paid or not charged for by the cancer clinical trial providers.

Eligible Expenses under this coverage will be paid on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits. The Eligible Expenses must be incurred while a Covered Person is insured for these benefits.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of the Policy.

AUTISM SPECTRUM DISORDER EXPENSE

Benefits are payable for Eligible Expenses incurred for the diagnosis and treatment of Autism Spectrum Disorder for a covered Dependent child nineteen (19) years of age or younger, or twenty-two (22) years of age or younger if the Dependent child is enrolled in high school. The Company will pay benefits on the same basis as any other Sickness according to the limits and maximums shown in the Schedule of Benefits, and subject to the limit stated below. The Eligible Expenses must be incurred while the Dependent child is insured for these benefits.

Eligible Expenses include:
(1) well-baby and well-child screening for diagnosing the presence of autism spectrum disorder; and
(2) treatment of autism spectrum disorder through speech therapy, occupational therapy, physical therapy and applied behavioral analysis.

Coverage under this provision shall be limited to:
(a) treatment that is prescribed by the Covered Person’s attending Doctor in accordance with a treatment plan;
(b) not more than thirty-six thousand dollars ($36,000) annually and shall not exceed two hundred thousand dollars ($200,000) in total lifetime benefits. Beginning January 1, 2011, the maximum benefit shall be adjusted annually on January 1 thereafter to reflect any change from the previous year in the medical component of the then-current consumer price index for all urban consumers published by the bureau of labor statistics of the United States Department of Labor.

Coverage under this provision shall not be denied on the basis that the services are habilitative or rehabilitative in nature.

No benefits will be payable for services received under the federal Individuals with Disabilities Education Improvement Act of 2004 and related state laws that place responsibility on state and local school boards for providing specialized education and related services to children three to twenty-two years of age who have autism spectrum disorder.

Treatment provided for Autism Spectrum Disorder must be prescribed by the covered Dependent child's Doctor in accordance with a treatment plan. The treatment plan shall include, but not be limited to, the following elements:
(1) the diagnosis;
(2) the proposed treatment by types;
(3) the frequency and duration of treatment;
(4) the anticipated outcomes stated as goals;
(5) the frequency with which the treatment plan will be updated; and
(6) the signature of the treating physician.

"Autism spectrum disorders" means a condition that meets the diagnostic criteria for the pervasive developmental disorders published in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition, text revision, also known as DSM-IV-TR, published by the American psychiatric association, including autistic disorder; Asperger's disorder; pervasive development disorder not otherwise specified; Rett's disorder; and childhood disintegrative disorder.

AUTISM SPECTRUM DISORDER EXPENSE (Continued)

"Habilitative or rehabilitative services" means treatment programs that are necessary to develop, maintain and restore to the maximum extent practicable the functioning of an individual.

“High school” means a school providing instruction for any of the grades nine through twelve.

No benefits will be paid for the Eligible Expenses above under any other similar benefit provision contained in this Policy.

This provision is subject to all of the terms of this Policy.

REPATRIATION OF REMAINS EXPENSE

Repatriation of Remains Benefit. If a Covered Person suffers loss of life due to Injury or Sickness while outside his or her home country, the Company will pay, subject to the limitations set out herein, for Eligible Expenses reasonably incurred to return his or her body to his or her current place of primary residence, but not exceeding the Maximum Amount per Covered Person.

Eligible Expenses include, but are not limited to: (1) embalming or cremation; (2) the most economical coffins or receptacles adequate for transportation of the remains; and (3) transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard in advance.

In addition to the Exclusions in the Exclusions and Limitations section of the Policy, Repatriation of Remains benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which the Covered Person is entitled to benefits under any Workers' Compensation Act or similar law.

MEDICAL EVACUATION EXPENSE

The Company will pay, subject to the limitations set out herein, for Eligible Medical Evacuation Expenses reasonably incurred if the Covered Person suffers an Injury or Sickness that warrants his or her Medical Evacuation while outside his or her home country, but not exceeding the Maximum Amount per Covered Person for all Medical Evacuations due to all Injuries from the same accident or all Sicknesses from the same or related causes.

The Doctor ordering the Medical Evacuation must certify that the severity of the Covered Person's Injury or Sickness warrants his or her Medical Evacuation. All Transportation arrangements made for the Medical Evacuation must be by the most direct and economical conveyance and route possible.

Travel Guard must make all arrangements and must authorize all expenses in advance for any Medical Evacuation benefits to be payable. The Company reserves the right to determine the benefits payable, including reductions, if it is not reasonably possible to contact Travel Guard in advance.

Eligible Medical Evacuation Expense(s) means an expense that: (1) is charged for a Medically Necessary Medical Evacuation Service; (2) does not exceed the usual level of charges for similar Transportation, treatment, services or supplies in the locality where the expense is incurred; and (3) does not include charges that would not have been made if no insurance existed.

Medical Evacuation means, if warranted by the severity of the Covered Person's Injury or Sickness: (1) the Covered Person's immediate Transportation from the place where he or she suffers an Injury or Sickness to the nearest hospital or other medical facility where appropriate medical treatment can be obtained; (2) the Covered Person's Transportation to his or her current place of primary residence to obtain further medical treatment in a Hospital or other medical facility or to recover after suffering an Injury or Sickness and being treated at a local hospital or other medical facility; or (3) both (1) and (2) above. A Medical Evacuation also includes medical treatment, medical services and medical supplies necessarily received in connection with such Transportation.

Medically Necessary Medical Evacuation Service means any Transportation, medical treatment, medical service or medical supply that: (1) is an essential part of a Medical Evacuation due to the Injury or Sickness for which it is prescribed or performed; (2) meets generally accepted standards of medical practice; and (3) either is ordered by a Doctor and performed under his or her care or supervision or order, or is required by the standard regulations of the conveyance transporting the Covered Person.

Transportation means moving the Covered Person during a Medical Evacuation by a land, water or air conveyance. Conveyances include, but are not limited to, air ambulances, land ambulances and private motor vehicles.

SECTION 7 - EXCLUSIONS AND LIMITATIONS

This Policy does not cover nor provide benefits for Loss or Expenses incurred:

1. as a result of dental treatment, except as provided elsewhere in this Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

2. for services normally provided without charge by the Policyholder's Health Center or by health care providers employed or retained by the Policyholder. The eligibility fee assessed by the Policyholder's Health Center is not a covered item.

3. for eye examinations (except as specifically provided), eyeglasses, contact lenses, or prescription for such or treatment for visual defects and problems. "Visual defects" means any physical defect of the eye which does or can impair normal vision apart from the disease process. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

4. for hearing examinations or hearing aids, except as provided herein; or other treatment for hearing defects and problems. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing apart from the disease process. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

5. as a result of an Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare-paying passenger in an aircraft operated by a commercial scheduled airline.

6. for Injury or Sickness resulting from war or act of war, declared or undeclared.

7. as a result of an Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law.

8. as a result of Injury sustained or Sickness contracted while in the service of the Armed Forces of any country. Upon the Covered Person entering the Armed Forces of any country, the Company will refund any unearned pro-rata premium. This does not include Reserve or National Guard Duty for training unless it exceeds 31 days.

9. for treatment provided in a government Hospital unless there is a legal obligation to pay such charges in the absence of insurance.

10. for cosmetic surgery except that "cosmetic surgery" shall not include reconstructive surgery when such surgery is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of a congenital disease or anomaly of a covered Dependent newborn child which has resulted in a functional defect. It also shall not include breast reconstructive surgery after a mastectomy.

11. for Injuries sustained as the result of a motor vehicle Accident to the extent provided for any loss or any portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable.

12. for preventive treatment, testing, medicines, serums, vaccines, vitamins contraceptive except as specifically provided in this Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

13. as a result of committing or attempting to commit an assault or felony or participation in a riot or civil commotion.

14. for Elective Treatment or elective surgery, except as specifically provided in this Policy.

15. after the date insurance terminates for a Covered Person except as may be specifically provided in the Extension of Benefits Provision.

16. for any services rendered by a Covered Person's Immediate Family Member.

17. for a treatment, service or supply which is not Medically Necessary.

18. for outpatient prescription drugs, except as specifically provided in this Policy.

19. for surgery and/or treatment of: allergy testing and anti-toxins; biofeedback-type services; breast implants or breast reduction; deviated nasal septum, including submucuous resection and/or other surgical correction thereof; family planning, except as specifically provided; hair growth or removal; sexual reassignment surgery and related therapy; skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; vasectomy; erectile dysfunction; and weight reduction. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

20. for routine physical examinations, health examinations or preschool physical examinations, except as specifically provided for in the Policy. This exclusion does not apply to Preventive Benefits mandated by the Patient Protection and Affordable Care Act.

21. for organ transplants.

22. for outpatient physiotherapy, except as specifically provided under this Policy.

23. for Injury resulting from: the practicing for, participating in, or traveling as a team member to and from intercollegiate, professional and semi-professional sports; hang gliding; sky diving; glider flying; sail planing. This exclusion does not apply to injuries sustained while participating in the UNM intramural program or UNM Club Sport Program or activities, which are not under auspices of the UNM Athletic Department but are conducted under the jurisdiction of the Policyholder.

24. for treatment in the Hospital emergency room which is not due to an Emergency Medical Condition.

25. for treatment, services, drugs, device, procedures or supplies that are Experimental or Investigational.

26. for treatment, services or supplies that are not deemed to be an Eligible Expense.

SECTION 7 - EXCLUSIONS AND LIMITATIONS

PRE-EXISTING CONDITIONS: In addition to Exclusions and Limitations, the Policy does not cover any medical treatment for Pre-existing Conditions as defined. This limitation does not apply:

(a) to the first $5000 of Expenses incurred per Policy Year; or
(b) the individual seeking coverage under the Policy has an aggregate of 18 months of Creditable Coverage and becomes eligible and applies for coverage under the Policy within 63 days of termination of prior Creditable Coverage; and
(c) if the individual's most recent prior Creditable Coverage was under an employer group health plan; and
(d) the individual accepted and used up COBRA continuation of coverage or similar state coverage if it was offered him or her.

Pre-existing Conditions limitation does not apply to:

(a) a newborn Dependent child; or
(b) a child adopted by the Covered Person or placed with the Covered Person for adoption, if adoption or placement for adoption occurs while covered under this Policy;
(c) pregnancy or Complications of Pregnancy;
(d) a Covered Person under age nineteen (19).

Creditable Coverage means coverage under any of the following:

(a) Any individual or group policy, contract or program, that is written or administered by a disability insurance company, health care service plan, fraternal benefits society, self-insured employee plan, or any other entity, and that arranges or provides medical, hospital and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation or a similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance;
(b) The federal Medicare Program pursuant to Title XVIII of the Social Security Act;
(c) The Medicaid program pursuant to Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
(d) Chapter 55 of Title 10, United States Code, the Civilian Health and Medical Program of the Uniformed Services;
(e) a medical care program of the Indian Health Service or of a tribal organization;
(f) a state health benefits risk pool;
(g) a health plan offered under chapter 89 of Title 5, United States Code, the Federal Employees Health Benefits Program;
(h) a public health plan as defined by federal regulations; or
(i) a health benefit plan under section 5(e) of the Peace Corps Act.

SECTION 8 – APPEAL PROCEDURES

DEFINITIONS

Adverse Determination means a denial, reduction, termination or rescission of, or a failure to provide or make payment (in whole or in part) for, a benefit.

An Adverse Determination includes a denial, reduction, termination or rescission of, or a failure to provide or make payment (in whole or in part) for, a benefit that is based on:

- A Covered Person's eligibility for benefits under the Policy;
- The results from the application of any utilization review;
- A determination that an item or service, for which benefits are otherwise provided, is experimental, investigational or not a Medical Necessity.

Appeal means a written request to the Company to reconsider an Adverse Determination.

Covered Person means a person who claims to be entitled to receive benefits from the Company. References to Covered Person with respect to notifications also include the Covered Person's authorized representative.

"**Emergency Medical Condition**" means a medical condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in: (a) jeopardy to the person's health or pregnancy; (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person; or serious jeopardy to the health of the Covered Person's fetus.

Internal Review Process means the procedure for an internal review of an Adverse Determination.

Medical Necessity means the providing of covered health care services or products that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms, in a manner that is:

- In accordance with generally accepted standards of medical practice;
- Consistent with the symptoms or treatment of the condition; and
- Not solely for anyone's convenience.

INTERNAL REVIEW PROCESS:

The Company will provide written notice of the Internal Review Process to Covered Persons following any Adverse Determination.

The Covered Person may submit an Appeal within 180 days of receiving written notice of an Adverse Determination. Within one (1) working day from receipt of the request, the Company will notify the Covered Person that the request has been received. If requested, the Company will provide written forms for submission of Appeals that will inform the Covered Person of the information necessary to pursue an appeal of an Adverse Determination.

If the Appeal is incomplete, the Company will immediately notify the Covered Person what information or materials is needed to make the Appeal complete. The Company may require that the Covered Person submit such written information or materials within 10 days of the Covered Person's receipt of the written form or as soon as reasonably possible. An Appeal shall be considered as received by the Company when the Company receives the written form, which the Covered Person purports to be complete.

Under circumstances where an Appeal may not contain sufficient information and the Company requests additional information, such request will not be burdensome or require such information as the Company might reasonably be expected to obtain through the Company's normal claims process.

APPEAL PROCEDURE

When an Appeal is made, the Company will assign the Appeal to a staff member who has had no prior direct involvement with the Covered Person's case to conduct the review.

The Covered Person will have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits, which the Company will review without regard to whether such information was submitted or considered in the initial benefit determination. The Company will provide the Covered Person, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits sufficiently in advance of the Appeal determination to give the Covered Person a reasonable opportunity to respond prior to such determination.

The review will be concluded as soon as possible in accordance with the medical exigencies of the case. Before the Company issues a determination that is based on new or additional rationale, the Covered Person will be provided, free of charge, with the rationale sufficiently in advance of the Appeal determination to give the Covered Person a reasonable opportunity to respond prior to such determination.

The Company will provide notice of an Adverse Determination either electronically or by U.S. mail. Such notice will be provided to the Covered Person or his or her Authorized Representative; and to the provider if the Adverse Determination involves the pre-service denial of treatment or procedure prescribed by the provider. The notice must include the following information:

(a) the specific reasons for the Adverse Determination;
(b) the specific policy provisions on which the determination is based;
(c) the Company's review procedures, including the Covered Person's right to a copy of the Company's records related to the Adverse Determination;
(d) the time limits applicable to the review; and
(e) the right of the Covered Person, his or her Authorized Representative or Health Care Provider to present evidence as part of a review of an Adverse Determination.

If the Adverse Determination is based on Medical Necessity, decisions related to experimental treatment, or a similar exclusion or limit involving the exercise of professional judgment, the notification must contain either an explanation of the scientific or clinical basis for the determination, the manner in which the terms of the Policy were applied to the Covered Person's medical circumstances, or a statement that such explanation is available free of charge upon request.

If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Determination, the notice must contain either the specific rule, guideline, protocol, or other similar criterion; or a statement that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge upon request.

SECTION 8 – APPEAL PROCEDURES

The notice of an Adverse Determination must include an explanation of the right to review the records of relevant information, including evidence used by the Company or its designee that influenced or supported the decision to make the Adverse Determination.

If the Company determines that additional information is necessary to perfect the denied claim, the Company must provide a description of the additional material or information that it requires, with an explanation of why it is necessary, as soon as the need is identified.

COVERED PERSON'S RIGHTS

a) The Company will not terminate or in any way penalize a Covered Person who exercises the right to appeal solely on the basis of filing the Appeal.

b) Assistance
   i. Upon the initiation of an Appeal, the Company will notify a Covered Person of the right to have a staff member appointed to assist her/him with understanding the Internal Review Process.
   ii. A Covered Person may request such assistance at any stage of the Internal Review Process.
   iii. Upon such request, the Company will appoint a staff member who has had no prior direct involvement in the case to assist the Covered Person.

c) After an Adverse Determination, a Covered Person will have the right to discuss a coverage determination with the staff member(s) who made the coverage determination.

If the Company does not adhere to all requirements of the Internal Review Process with respect to a claim, the Covered Person is deemed to have exhausted all internal appeals processes and may initiate an external review.

I THE COVERED PERSON'S RIGHT TO AN EXTERNAL APPEAL REVIEW

The Company will provide written notice of the right to an external review to Covered Persons following any Adverse Determination or final internal Adverse Determination. The Covered Person or authorized representative may file a written request for an external review with the external review examiner (hereafter referred to as the examiner) within four months after the date of receipt of a notice of an Adverse Determination or final internal Adverse Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

A Covered Person may make a written or oral request of an expedited external review with the examiner at the time the Covered Person receives:

- An Adverse Determination that involves an Emergency Medical Condition; and the Covered Person has filed a request for an expedited internal appeal; or
- An Adverse Determination that concerns an admission, availability of care, continued stay or health Care item or service for which the Covered Person received services, but has not been discharged from a facility; and the Covered Person has filed a request for an expedited internal appeal; or
- A final internal Adverse Determination that involves an Emergency Medical Condition; or
- A final internal Adverse Determination that concerns an admission, availability of care, continued stay or health care item or service for which the Covered Person received services, but has not been discharged from a facility.

II THE EXTERNAL APPEAL REVIEW PROCESS

The examiner will review all of the information and documents timely received. In reaching a decision, the examiner will review the claim from the beginning and not be bound by any decisions or conclusions reached during the Company's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service Act.

The examiner will forward all documents submitted directly to the examiner by the Covered Person to the Company. Upon receipt of any information submitted by the Covered Person, the examiner must within one business day forward the information to the Company. Upon receipt of any such information, the Company may reconsider its Adverse Determination or final internal Adverse Determination that is the subject of the external review. Reconsideration by the Company must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Company decides, upon completion of its reconsideration, to reverse its Adverse Determination or final internal Adverse Determination and provide coverage or payment. Within one business day after making a decision to reverse, the Company must provide written notice of its decision to the Covered Person and the examiner. The examiner must terminate the external review upon receipt of the notice from the Company.

The examiner must provide written notice of the final external review decision as expeditiously as possible and within 45 days after the examiner receives the request for the external review. For expedited external reviews, the examiner must provide notice of the final external review decision within 72 hours after the examiner receives the request for the external review. For individuals with an Emergency Medical Condition who are also in an ongoing course of treatment for that condition, the external review decision must be provided within 24 hours. The examiner must deliver the notice of final external review decision to the Covered Person and the Company.

The examiner's final external review decision notice will contain:

(i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial, including denial codes);

(ii) The date the examiner received the assignment to conduct the external review and the date of the examiner's decision;

(iii) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

(iv) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(v) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Company or to the Covered Person;

(vi) A statement that judicial review may be available to the Covered Person; and

(vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793.

After a final external review decision, the examiner must maintain records of all claims and notices associated with the external review process for six years. The examiner must make such records available for examination by the Covered Person or Company upon request.

NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA.

Executive Offices: 175 Water Street, 18th Floor, New York, NY 10038
(212) 458-5000
(a capital stock company, herein referred to as the Company)

APPLICATION FOR STUDENT BLANKET ACCIDENT AND SICKNESS INSURANCE POLICY

The University of New Mexico
(the Policyholder)

Student Health Center, MSCO6-3870, Alburquerque, NM 87131-1056
(Policyholder's Address)

CAS9495331	**CHH0058674**
(Policy Number)	**(Reference Number)**

applies for the following insurance under and in accordance with the Student Blanket Accident and Sickness Insurance Policy:

ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN A

COVERAGE PROVISIONS:

HOSPITAL EXPENSE
SURGICAL EXPENSE
IN-HOSPITAL DOCTOR'S FEES EXPENSE
OUTPATIENT EXPENSE
OUT OF HOSPITAL DOCTOR'S FEES EXPENSE
CONSULTANT'S FEES EXPENSE
AMBULANCE EXPENSE
DENTAL EXPENSE
OPTIONAL DENTAL TREATMENT EXPENSE
PRESCRIBED MEDICINES EXPENSE
ABORTION EXPENSE
MENTAL AND NERVOUS DISORDERS EXPENSE
ALCOHOLISM AND SUBSTANCE ABUSE EXPENSE
OPTIONAL VISION CARE EXPENSE

ACCIDENT AND SICKNESS EXPENSE BENEFIT- PLAN B

COVERAGE PROVISIONS:

HOSPITAL EXPENSE
SURGICAL EXPENSE
IN-HOSPITAL DOCTOR'S FEES EXPENSE
OUTPATIENT EXPENSE
OUT OF HOSPITAL DOCTOR'S FEES EXPENSE
CONSULTANT'S FEES EXPENSE
AMBULANCE EXPENSE
DENTAL EXPENSE
OPTIONAL DENTAL TREATMENT EXPENSE
PRESCRIBED MEDICINES EXPENSE
ABORTION EXPENSE
MENTAL AND NERVOUS DISORDERS EXPENSE
ALCOHOLISM AND SUBSTANCE ABUSE EXPENSE
OPTIONAL VISION CARE EXPENSE

ACCIDENT AND SICKNESS EXPENSE BENEFIT- APPLICABLE TO PLANS A OR B

COVERAGE PROVISIONS:

DIABETES EXPENSE
SMOKING CESSATION TREATMENT
CHILDHOOD IMMUNIZATION EXPENSE
MAMMOGRAPHY AND CYTOLOGICAL SCREENING EXPENSE
COLORECTAL CANCER SCREENING EXPENSE
RECONSTRUCTIVE BREAST SURGERY
PROSTATE CANCER SCREENING
TMJ EXPENSE
HEARING AIDS EXPENSE
TREATMENT OF INBORN ERRORS OF METABOLISM EXPENSE
EMERGENCY CARE EXPENSE
DENTAL ANESTHESIA EXPENSE
MATERNITY TESTING EXPENSE
EARLY CHILDHOOD INTERVENTION SERVICES EXPENSE
CLINICAL TRIALS EXPENSE
AUTISM SPECTRUM DISORDER EXPENSE

REPATRIATION OF REMAINS EXPENSE BENEFIT PER INJURY OR SICKNESS
MEDICAL EVACUATION EXPENSE BENEFIT PER INJURY OR SICKNESS

Policyholder Riders and/or Endorsements:
The following Riders and/or Endorsements are attached to and made part of the Policy as of the Policy Effective Date. Each Rider and/or Endorsement is subject to all provisions, limitations and exclusions of the Policy that are not specifically modified by the Rider and/or Endorsement.

FORM NO.	**DESCRIPTION**
89644 (7/05)	Coverage Territory Endorsement

Premiums:
It is hereby agreed and understood that the premium amounts, and the manner in which premiums are due and payable, are as follows:

Plan A*	Annual	Fall	Spring/Summer
Student	$1,893	$795	$1,113
Spouse	$5,993	$2,504	$3,504
Each Child	$2,538	$1,064	$1,489

Plan B*	Annual	Fall	Spring/Summer
Student	$1,096	$463	$648
Spouse	$4,385	$1,834	$2,566
Each Child	$1,383	$583	$815

*Rates do not include administrative fees.

This application is attached to, and made part of, the Student Blanket Accident and Sickness Insurance Policy.

The Student Blanket Accident and Sickness Policy has been approved, and its terms accepted, by the Policyholder.

No change in the Policy shall be valid unless approved by an officer of the Company. The approval must be noted on or attached to the Policy. No agent has authority to change the Policy or to waive any of its provisions.

***Policyholder Effective Date:** **July 15, 2013 (earliest)**
***Policyholder Termination Date:** **August 18, 2014 (latest)**

*Specific Effective and Termination Dates:

- July 15, 2013 – July 14, 2014 for Students enrolled in the Medical Doctorate Program; or
- July 16, 2013 – July 14, 2014 for Students enrolled in the Medical Doctorate Program maintaining continuous coverage from the prior Policy Year; or
- August 19, 2013 – August 18, 2014 for all regular students; or
- August 20, 2013 – August 18, 2014 for Covered Students maintaining continuous coverage from the prior Policy Year; or
- If elected and additional premium is paid, up to 3 weeks prior to August 19, 2013 for Students who arrive on campus early. Termination Date is August 18, 2014.

Dated at _____ 2013

_____
Signed for the Policyholder

_____
Title

_____
Date

_____
Signed by Licensed Resident Agent
(Where Required by Law)

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil files and criminal penalties.