Student Health Insurance Plan

Plan Year 17/18

Designed Exclusively for the students of the School of Medicine, School of Dental Medicine, and School of Dental Medicine-Orthodontics:

University of Nevada Las Vegas

2017 - 2018

Policy Number: 2017I5B84
Group Number: ST1039SH

School of Medicine and School of Dental Medicine-Orthodontics—Effective: 7/1/2017 - 7/1/2018

School of Dental Medicine—Effective: 8/25/2017 - 8/25/2018

Administered by:
Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA
When you need care, consider the UNLV Student Health Center (SHC) on campus as your first stop. They can provide many of the routine health services you need. Services obtained at the SHC are covered at no cost to the member with all applicable deductibles, copays and coinsurance waived for medical services. **The UNLV SHC is open Monday through Thursday from 8:00 a.m. to 6:00 p.m. and Friday 9:00 a.m. to 5:00 p.m.**

For more information, call the Student Health Center at (702) 895-3370. In the event of an emergency, call 911 or the Campus Police at (702) 895-3668.

A SHC referral is not required, and it does not guarantee services received will be considered eligible expenses under the plan, nor is it a guarantee of payment.

Insured dependents are not eligible to use the UNLV SHC. The benefits listed in the Schedule of Benefits are available to the insured dependents.

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## ELIGIBILITY AND WAIVER OF COVERAGE

### School of Medicine Students

All registered degree seeking School of Medicine students are automatically enrolled in the UNLV sponsored Student Health Insurance Plan (SHIP) unless an online waiver with proof of comparable coverage is submitted before the deadline date and approved. Premiums are collected by the Cashier’s office with tuition during registration.

### School of Dental Medicine DMD, DDS, Orthodontic (Resident and Fellowship), and Pediatric Students

All registered degree seeking School of Dental Medicine DMD, DDS, Orthodontic (Resident and Fellowship), and Pediatric students are **required to purchase this insurance plan** unless proof of comparable coverage is furnished and an online waiver is submitted before the deadline date and approved. Premiums are collected by the Cashier’s office with tuition during registration.

### Eligibility

To be eligible for coverage under the policy, a student must:

1. Meet the enrollment requirements stated in the Insurance Information Schedule; and
2. Pay the required premium; and
3. Attend classes for at least the first 31 days of the period for which premium has been paid except in the case of medical withdrawal.

We maintain the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that they have not been met, Our only obligation is to refund premium.

### INSURANCE PAYMENTS WITH PERSONAL CHECK

For direct enrollments with USI Student Insurance that are not charged to your UNLV student account: If you make your insurance payment via personal check payable to USI Student Insurance and we are un-able to process the check (due to insufficient funds, closure of account, etc.), your and your eligible Dependents’ insurance coverage will be terminated retroactive to the effective date of the enrolled term.
REFUND OF PREMIUM

Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:

1. For any student who does not attend school during the first thirty-one (31) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium will be made.

2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

No other refunds will be allowed.

COVERAGE FOR ELIGIBLE DEPENDENTS

Eligible individuals may also insure, on a Voluntary Participation Basis, their eligible Dependents. Eligible Dependents are the spouse (or domestic partner), and unmarried children under 26 years of age. Individuals who enroll their eligible Dependents must enroll them by the published enrollment deadline (page 3) with the exception of adopted children or newborn children (see the Policy’s provision entitled Dependent Child Coverage).

A “Newborn” will automatically be covered for Injury or Sickness from birth until 31 days old, providing that the student is covered under this plan. Coverage may be continued for that child when USI Student Insurance Services is notified in writing or by phone within 31 days from the date of birth and by payment of any additional premium. Dependent coverage expires concurrently with that of the Insured Student, and eligible Dependents must re-enroll when coverage terminates to maintain coverage.

EFFECTIVE DATES AND COSTS

Coverage Dates for School of Medicine and School of Dental Medicine-Orthodontics Students and their Eligible Dependents

The Policy is issued as a new policy for the term July 1, 2017 to July 1, 2018 as Policy Number 2017I5B84. All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Coverage Start Date</th>
<th>Coverage End Date</th>
<th>Enrollment/Waiver Deadline</th>
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<tr>
<td>Annual</td>
<td>7/1/17</td>
<td>7/1/18</td>
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Rates for School of Medicine Students and their Eligible Dependents*

Dependent rates are in addition to the student rate.

<table>
<thead>
<tr>
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<tr>
<td>Student</td>
<td>$2,311.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,311.00</td>
</tr>
<tr>
<td>Each Child (Age 0-26)</td>
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</tr>
<tr>
<td>3 or more Children (Age 0-26)</td>
<td>$6,933.00</td>
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</tbody>
</table>

*Rates include a premium payable to CHP Student Health, as well as administrative fees pay-able to UNLV and USI Student Insurance. Rates also include Medical Evacuation and Repatriation and Worldwide Emergency Travel Assistance benefits/services provided through Travel Guard and its contracted underwriting companies.
Coverage Dates for School of Dental Medicine Students and their Eligible Dependents.


All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.

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Rates for School of Dental Medicine and School of Dental Medicine-Orthodontics Students and their Eligible Dependents*

Dependent rates are in addition to the student rate.

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WITHDRAWAL FROM SCHOOL

If you leave the University of Nevada, Las Vegas for reason of a covered accident or sickness, you will be eligible for continued coverage under this Plan for the period premium has been paid. Unless proof of acceptable coverage is provided, enrollment is automatic. All applicable enrollment deadline dates apply. You must pay the applicable insurance premium.

Please make sure you understand your school’s credit hour and other requirements for enrolling in this plan. We reserve the right to review, at any time, your eligibility to enroll in this plan. If it is determined that you did not meet the school’s eligibility requirements for enrollment, your participation in the plan may be terminated or rescinded in accordance with its terms and applicable law.

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Underwritten by:
National Guardian Life Insurance Company
Madison, WI

National Guardian Life Insurance Company is not affiliated with Guardian Life Insurance Company of America aka The Guardian or Guardian Life.
Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, USI Student Insurance at 10940 White Rock Rd., Rancho Cordova, CA 95670, Phone: (800) 853-5899, www.studentinsurance.usi.com or Consolidated Health Plans at 877-657-5033.

COVERAGE

1. **School of Medicine and School of Dental Medicine-Orthodontics Students:**
   Accident and Sickness coverage begins on July 1, 2017, or the date of enrollment in the plan, whichever is later and ends July 1, 2018.

   **School of Dental Medicine Students:**
   Accident and Sickness coverage begins on August 25, 2017, or the date of enrollment in the plan, whichever is later and ends August 25, 2018.

2. Benefits are payable during the Policy Term, subject to any Extension of Benefits.

3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.

CERTIFICATE OF
STUDENT BLANKET HEALTH INSURANCE
issued by
NATIONAL GUARDIAN LIFE INSURANCE COMPANY, PO BOX 1191, Madison, WI 53701-1191
(Herein referred to as ‘We’, ‘Us’ or ‘Our’)

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2015) NV (“the Policy”).

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Section 1 — Definitions
The terms listed below, if used in this Certificate, have the meanings stated.

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

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

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

**Applied Behavior Analysis** means the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including, without limitation, the use of direct observation, measurement and functional analysis of the relations between environment and behavior.

**Autism Spectrum Disorders** means a neurobiological medical condition including, without limitation, autistic disorder, Asperger’s Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

**Behavioral Therapy** means any interactive therapy derived from Evidence-based Research, including, without limitation, discrete trial training, early intensive behavioral intervention, intensive intervention programs, pivotal response training and verbal behavior provided by a licensed psychologist, Licensed Behavior Analyst, Licensed Assistant Behavior Analyst or Certified Autism Behavior Interventionist.

**Brand Name Drugs** means drugs for which the drug manufacturer’s trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.
Certified Autism Behavior Interventionist means a person who is certified as an autism behavior interventionist by the Board of Psychological Examiners and who provides behavior therapy under the supervision of:
1. A licensed psychologist;
2. A Licensed Behavior Analyst; or
3. A Licensed Assistant Behavior Analyst.

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

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

Cooperative Group means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes the Clinical Trials Cooperative Group Program and the Community Clinical Oncology Program.

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

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

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

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

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

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

Dependent means:
1. An Insured Student’s lawful spouse or lawful Domestic Partner;
2. An Insured Student’s dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student’s unmarried biological or adopted child or stepchild who has reached age 26 and who is:
   a. Primarily dependent upon the Insured Student for support and maintenance; and
   b. Incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

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

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

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

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

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

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

**Essential Health Benefits** mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

**Evidence-based Research** means research that applies rigorous, systematic and objective procedures to obtain valid knowledge relevant to Autism Spectrum Disorders.

**Facility Authorized to Conduct Phase I Clinical Trials or Studies for the Treatment of Cancer** means a facility or an affiliate of a facility that:
1. Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;
2. Operates a protocol review and monitoring system which conforms to the standards set forth in the Policies and Guidelines Relating to the Cancer-Center Support Grant published by the Cancer Centers Branch of the National Cancer Institute;
3. Employs at least two researchers and at least one of those researchers receives funding from a federal grant;
4. Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;
5. Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;
6. Is capable of gathering, maintaining and reporting electronic data; and
7. Is capable of responding to audits instituted by federal and state agencies.

**Formulary** means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

**Generic Drugs** means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

**Habilitative Services** means Medically Necessary health care services and health care devices that assist an Insured Person in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an Insured Person’s environment. Habilitative Services does not include respite care, day care,
recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training.

**Habilitation or Rehabilitative Care as they apply to the Autism Benefit** means counseling, guidance and professional services and treatment programs, including, without limitation, applied behavior analysis, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of a person.

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

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

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

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

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

**Inherited Metabolic Disease** means a disease caused by an inherited abnormality of the body chemistry of a person.

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

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

**Leave of Absence** means a planned interruption in a registered Student’s education and may be granted up to one semester.

**Licensed Assistant Behavior Analyst** means a person who holds current certification or meets the standards to be certified as a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization, who is licensed as an assistant behavior analyst by the Board of Psychological Examiners and who provides Behavioral Therapy under the supervision of a licensed behavior analyst or psychologist.

**Licensed Behavior Analyst** means a person who holds current certification or meets the standards to be certified as a board certified behavior analyst or a board certified assistant behavior analyst issued by the Behavior Analyst Certification Board, Inc., or any successor in interest to that organization and who is licensed as a behavior analyst by the Board of Psychological Examiners.

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

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

**Mental Illness** means a clinically significant disorder of thought, mood, perception, orientation, memory or behavior which:
1. Is listed in the most recent edition of the clinical manual of the International Classification of Diseases, ICD-9-CM, code range 295 to 302.9, inclusive, 306 to 309.9, inclusive, or 311 to 316, inclusive, or the corresponding code in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Axis I; and
2. Seriously limits the capacity of an Insured Person to function in the primary aspects of daily living, including, without limitation, personal relations, living arrangements, employment and recreation.

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

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

who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered. A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

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

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

Prescription Care means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

Psychological Care means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

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

Screening for Diagnosis of Autism Spectrum Disorders means Medically Necessary assessments, evaluations or tests to screen and diagnose whether a person has an autism spectrum disorder.

Therapeutic Care means services provided by licensed or certified speech pathologists, occupational therapists and physical therapists.

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

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

Special Food Product means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a Physician for the dietary treatment of an Inherited Metabolic Disease. The term does not include a food that is naturally low in protein.

Specialty Drugs means drugs that are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the Insured Person’s drug therapy.

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

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

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

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

Treatment Plan as it applies to the Autism Benefit means a plan to treat an autism spectrum disorder that is prescribed by a licensed Physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a Licensed Behavior Analyst.

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

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

You, Your means a student of the Policyholder who is eligible and insured for coverage under the policy.
Section 2 – Eligibility, Enrollment and Termination
All registered degree seeking School of Medicine students are automatically enrolled in the UNLV sponsored Student Health Insurance Plan (SHIP) unless an online waiver with proof of comparable coverage is submitted before the deadline date and approved. Premiums are collected by the Cashier’s office with tuition during registration.

All registered degree seeking School of Dental Medicine DMD, DDS, Orthodontic (Resident and Fellowship), and Pediatric students are required to purchase this insurance plan unless proof of comparable coverage is furnished and an online waiver is submitted before the deadline date and approved. Premiums are collected by the Cashier’s office with tuition during registration.

Termination Dates: An Insured Person’s insurance will terminate on the earliest of: 1) The date the policy terminates for all insured persons; or 2) The end of the period of coverage for which premium has been paid; or 3) The date an Insured Person ceases to be eligible for the insurance; or 4) The date an Insured Person enters military service; or 5) On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error.

Extension of Benefits: Coverage under the Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended as follows: 1) If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for a minimum of 31 days from the Termination Date while such confinement continues.

Section 3 — BENEFITS
Benefits are payable under the policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Insured Person. The Covered Medical Expenses for an issued Policy will be only those listed in the Schedule of Benefits. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits. Subject to payment of any required Deductible, when you suffer a Loss from Covered Accident or Covered Sickness, we will pay benefits as follows:

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

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

Benefit Period: The first treatment of a Covered Injury or Covered Sickness must begin within the time stated in the Benefit Period shown in the Schedule of Benefits. A Benefit Period begins when the Insured Person experiences a Loss due to Covered Injury or Covered Sickness. The Benefit Period terminates at the end of the period defined in the Schedule of Benefits. Any extension of a Benefit Period, if provided elsewhere in the policy, is limited to medical treatment of the Covered Injury or Covered Sickness that is ongoing on the termination date of the Insured Person’s coverage. The Insured Person’s termination date of coverage as it would apply to any other Covered Injury or Covered Sickness will not be affected by such extension.

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

**SCHEDULE OF BENEFITS**
**GOLD PLAN**

**PREFERRED PROVIDER ORGANIZATION (PPO)**

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

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

Note, however, that We will pay at the PPO Allowance level for treatment by a Non-Network Provider if: there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.

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

<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Usual and Reasonable charge when services are provided through a Network Provider.</td>
<td>Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum.</td>
</tr>
<tr>
<td>Deductible (Per Individual per Policy Year)</td>
<td>$250</td>
<td>$500</td>
</tr>
<tr>
<td>Out-of-Pocket Expense Limit (Per Policy Year)</td>
<td>Individual $3,750 Family $7,500</td>
<td>Individual $7,500 Family $15,000</td>
</tr>
<tr>
<td>Coinsurance Amount</td>
<td>80% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.</td>
</tr>
<tr>
<td>Inpatient Benefits</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Hospital Room &amp; Board Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room &amp; Board Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses for services &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Physician’s Visits while Confined</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Inpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Physical Therapy (inpatient)</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Skilled Nursing Facility Expense Benefit</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Extended Care Benefit</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Nervous, Mental or Emotional Disorders Treatment Expense</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
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</tr>
<tr>
<td><strong>Outpatient Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Service</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Outpatient Surgery Miscellaneous</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>(excluding not-scheduled surgery)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>— expenses for services &amp; supplies,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>such as cost of operating room,</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>therapeutic services, misc.</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>supplies, oxygen, oxygen tent, and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>blood &amp; plasma</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Rehabilitation Therapy including</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>cardiac rehabilitation, pulmonary</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>rehabilitation, physical therapy,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>occupational therapy and speech</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>therapy</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Habilitative Services are covered</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>to the extent that they are</td>
<td>Copayment: $25.00</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Medically Necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Copayment: $25.00</td>
<td>Copayment: $25.00</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Copayment: $100.00</td>
<td>Copayment: $100</td>
</tr>
<tr>
<td></td>
<td>Copayment waived if admitted</td>
<td>Copayment waived if admitted</td>
</tr>
<tr>
<td>In Office Physician’s Visits</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Copayment: $25.00</td>
<td>Copayment: $25.00</td>
</tr>
<tr>
<td>Diagnostic X-ray Services</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Laboratory Procedures</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>(Outpatient)</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Copayment: $15.00 Generic</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copayment: $45.00 Preferred Brand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Copayment: $75.00 Brand</td>
<td></td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------</td>
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</tr>
<tr>
<td>Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hospice Care Coverage Up to 5 days per policy year</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Nervous, Mental or Emotional Disorders Treatment</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td><strong>Other Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Prosthesis and Orthotics</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Pediatric Dental Care Benefit Preventive Dental Care</td>
<td>See Benefit for limitations 100%, limited to 1 dental exams every 6 months</td>
<td>See Benefit for limitations 50%, limited to 1 dental exams every 6 months</td>
</tr>
<tr>
<td>The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care: Emergency Dental Clinical Oral Evaluations Endodontic Services Periodontal Services Prosthodontic Services Medically Necessary Orthodontic Care</td>
<td>50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable</td>
<td>50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable</td>
</tr>
<tr>
<td>Pediatric Vision Care Benefit Limited to 1 visit and 1 pair of prescribed lenses and frames per policy year</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Mental Illness Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Consultant Physician Services – when requested by the attending physician</td>
<td>80% of PPO Allowance for Covered Medical Expense Copayment: $25.00</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Copayment: $25.00</td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment for Insured Person’s over age 18</td>
<td>80% of PPO Allowance for Covered Medical Expense</td>
<td>50% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Sickness Dental Expense for Insured Persons over age 18</td>
<td>80% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Student Health Center/Infirmary Expense</td>
<td>100% of Usual and Reasonable Charges for Covered Medical Expenses Deductible Waived</td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation Expense –</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>Repatriation Expense –</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
</tbody>
</table>

**MANDATED BENEFITS**

| Clinical Trials for Cancer or Chronic Fatigue Syndrome Benefit | 80% of PPO Allowance for Covered Medical Expense | 50% of Usual and Reasonable Charge for Covered Medical Expenses |
| Human Papillomavirus Vaccine Benefit | 80% of PPO Allowance for Covered Medical Expense | 50% of Usual and Reasonable Charge for Covered Medical Expenses |
| Autism Spectrum Disorder Benefit | Same as any other Covered Sickness | Same as any other Covered Sickness |
| Enteral Formula Benefit | Same as any other Covered Sickness | Same as any other Covered Sickness |
| Management and Treatment of Diabetes Benefit | 80% of PPO Allowance for Covered Medical Expense | 50% of Usual and Reasonable Charge for Covered Medical Expenses |
| Mastectomy and Reconstructive Surgery Benefit | 80% of PPO Allowance for Covered Medical Expense | 50% of Usual and Reasonable Charge for Covered Medical Expenses |
| Temporomandibular Joint Syndrome Benefit | 80% of PPO Allowance for Covered Medical Expense | 50% of Usual and Reasonable Charge for Covered Medical Expenses |
| Mental Illness Benefit | Same as any other Covered Sickness | Same as any other Covered Sickness |
| Treatment of Substance Abuse Benefit | 80% of PPO Allowance for Covered Medical Expense Up to the limits described in the Benefit | 50% of Usual and Reasonable Charge for Covered Medical Expenses Up to the limits described in the Benefit |
Covered Medical Expenses
We will pay the Usual and Reasonable charges incurred for Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness. The Covered Medical Expenses for an issued Policy will be only those listed below and as shown in the Schedule of Benefits.

Inpatient Benefits

1. **Hospital Room and Board Expense**, including general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed.
2. **Intensive Care Unit**, including 24-hour nursing care. This benefit is NOT payable in addition to room and board charges incurred on the same date.
3. **Hospital Miscellaneous Expenses**, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
   a. The cost for use of an operating room;
   b. Prescribed medicines;
   c. Laboratory tests;
   d. Therapeutic services;
   e. X-ray examinations;
   f. Casts and temporary surgical appliances;
   g. Oxygen, oxygen tent;
   h. Blood and blood plasma; and
   i. Miscellaneous supplies.
4. **Preadmission Testing** - We will pay the charges for routine tests performed as a preliminary to the Insured Person’s being admitted to a Hospital. These tests must be performed within three working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI’s, NMR’s, and blood chemistries.
5. **Physician’s Visits while Confined** – We will pay the expenses incurred for Physician’s visits not to exceed one visit per day. Physician’s visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon’s fees are not payable under this benefit.
6. **Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** – We will pay benefits for inpatient surgery (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician’s visits.

Benefits for Bariatric Surgery are limited to the benefit shown in the Schedule of Benefits and include gastric restrictive surgery services for extreme obesity under the following circumstances only. The Insured Person must have a body mass index (BMI) of greater than 40kg/m2 or have a BMI greater than 35kg/m2 with significant co-morbidities. The Insured Person must provide acceptable documented evidence that dietary attempts at weight control are ineffective and be at least 18 years old. Attendance at a medically supervised weight loss program within the last 24 months for at least three (3) months is required with documented failure of weight loss.

Benefits also include the following Medically Necessary Human Organ and Tissue Transplant surgery to the extent that the surgery is not Experimental or Investigational Treatment: autologous and nonautologous bone marrow, cornea, kidney, liver, heart, lung, heart/lung, pancreas, and pancreas/kidney transplants.

Related to Human Organ and Tissue Transplant surgery, We will also pay for the following benefits:

- **Reasonable and necessary travel expenses** when the Insured Person is required to travel more than 75 miles from his or her residence to the facility where the transplant will be performed including transportation to and from the facility and lodging for the Insured Person and one companion for up to $200 per day. If the Insured Person is a minor, We will pay the reasonable and necessary travel expenses for transportation and lodging for two companions. We will pay up to $15,000 per transplant procedure.
b. Reasonable and necessary expenses incurred for a donor search and procurement for a person who is not related to the Insured Person by blood, marriage, or domestic partnership. We will pay for up to $15,000 per transplant.

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

8. **Rehabilitative Services and Habilitative Services Confined** - We will pay the expenses incurred for inpatient rehabilitation services including physical therapy, occupational therapy, and speech therapy due to a Covered Injury or Covered Sickness and Habilitative Services when prescribed by the attending Physician.

9. **Skilled Nursing Facility Expense Benefit** - the expenses incurred for the services, supplies and treatments rendered to an Insured Person by a Skilled Nursing Facility. The Insured Person must enter an Skilled Nursing Facility:
   a. Within seven (7) days after his/her discharge from a Hospital confinement;
   b. Such confinement must be of at least three (3) consecutive days that began while coverage was in force under the policy; and
   c. Was for the same or related Sickness or Accident;

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

**Outpatient Benefits**

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

   Benefits for Bariatric Surgery are limited to the benefit shown in the Schedule of Benefits and include gastric restrictive surgery services for extreme obesity under the following circumstances only. The Insure Person must have a body mass index (BMI) of greater than 40kg/m2 or have a BMI greater than 35kg/m2 with significant comorbidities. The Insured Person must provide acceptable documented evidence that dietary attempts at weight control are ineffective and be at least 18 years old. Attendance at a medically supervised weight loss program within the last 24 months for at least three (3) months is required with documented failure of weight loss.

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

3. **Rehabilitative Services and Habilitative Services** - We will pay the expenses incurred for outpatient rehabilitation services including physical therapy, occupational therapy, and speech therapy due to a Covered Injury or Covered Sickness and Habilitative Services when prescribed by the attending Physician.

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

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

6. **Diagnostic X-ray Services** – We will provide coverage for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a physician.

7. **Laboratory Procedures (Outpatient)** – We will provide coverage for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

8. **Prescription Drugs** -
   a. We will pay the expenses incurred for medication for which a Physician’s written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made. Also covered are prescribed contraceptives and hormone replacement therapies.
   b. **Off-Label Drug Treatments** - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
      i. The drug is approved by the FDA;
      ii. The drug is prescribed for the treatment of a life-threatening condition including cancer;
      iii. The drug has been recognized for treatment of that condition by one of the following:
         (a) The American Medical Association Drug Evaluations;
         (b) The American Hospital Formulary Service Drug Information.
         (c) The United State Pharmacopoeia Dispensing Information, volume 1, “Drug Information for Health Care Professionals”, or
         (d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

      When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items i., ii., and iii. of this benefit.

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

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

c. **Contraceptives and Hormone Replacement Therapy**: Prescription Drug(s) will also include any type of drug or device for contraception and any type of hormone replacement therapy which is lawfully prescribed or ordered by a Physician and which has been approved by the Food and Drug Administration. This benefit does not cover fertility drugs.

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

10. **Home Health Care Expense** - We will pay the charges incurred for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary. Benefits include private duty nursing in addition to care by a home health aide according to a treatment plan prescribed by a qualified Physician. Home Health Care visits related to maternity care will be payable under the Maternity Benefit and not this Benefit.

11. **Hospice Care Coverage** - When, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare. We will also pay for 5 bereavement sessions provided to Immediate Family Members as long as they are provided within six (6) months of the Insured Person’s death.

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

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

Other Benefits

1. Ambulance Service – We will pay the expenses incurred for transportation to or from a Hospital by ground and air ambulance. Subject to the Claims Provisions, We will provide for the direct reimbursement of a provider of medical transportation for covered services if that provider does not receive reimbursement from any other source.

2. Prosthetics and Orthotics - When prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We will also not pay for prosthetics or orthotics when used as protective devices during a student’s participation in sports. Replacement prosthetics and orthotics are not covered.

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

4. Maternity Benefit - We will pay the expenses incurred for prenatal care and maternity charges as follows:
   a. Hospital stays for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness.
   b. Inpatient Physician charges or surgeon charges will be covered the same as for any other Covered Sickness for both mother and newborn child.
   c. Physician-directed Follow-up Care including:
      1) Physician assessment of the mother and newborn;
      2) Parent education;
      3) Assistance and training in breast or bottle feeding;
      4) Assessment of the home support system;
      5) Performance of any prescribed clinical tests; and
      6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.
   d. Outpatient Physician’s visits will be covered the same as for any other Covered Sickness.

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

6. **Pediatric Dental Care** - We will pay the Usual and Reasonable expenses incurred for the following dental care 
services for Insured Persons up to age 19.

   a. Emergency dental care, which includes emergency treatment required to alleviate pain and suffering 
caused by dental disease or trauma.
   
   b. Preventive dental care, which includes procedures which help to prevent oral disease from occurring, 
including:
      - Prophylaxis (scaling and polishing the teeth at six (6) month intervals);
      - Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
      - Sealants on unrestored permanent molar teeth; and
      - Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition 
to maintain space for normally developing permanent teeth.

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

   d. Endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where 
Hospitalization is not required.
      - Prosthodontic services as follows:
        - Removable complete or partial dentures, including six (6) months follow-up care; and
        - Additional services include insertion of identification slips, repairs, relines and rebases and treatment 
of cleft palate.

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

   e. Orthodontics used to help restore oral structures to health and function and to treat serious medical 
conditions such as:  cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper 
or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of 
the temporomandibular joint; and other significant skeletal dysplasias.
      - Procedures include but are not limited to:
        - Rapid Palatal Expansion (RPE);
        - Placement of component parts (e.g. brackets, bands);
        - Interceptive orthodontic treatment;
        - Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active 
treatment and periodically adjusted);
        - Removable appliance therapy; and
        - Orthodontic retention (removal of appliances, construction and placement of retainers).

7. **Pediatric Vision Care** - We will pay the Usual and Reasonable expenses incurred for emergency, preventive 
and routine vision care for Insured Persons up to age 19.
a. Vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:
   (1) Case history;
   (2) External examination of the eye or internal examination of the eye;
   (3) Ophthalmoscopic exam;
   (4) Determination of refractive status;
   (5) Binocular distance;
   (6) Tonometry tests for glaucoma;
   (7) Gross visual fields and color vision testing; and
   (8) Summary findings and recommendation for corrective lenses.

b. Prescription lenses or contact lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new frames more frequently, as evidenced by appropriate documentation.

8. **Infertility Services** - We will pay the Usual and Reasonable expenses incurred for laboratory studies and diagnostic procedures for infertility. The Insured Person and the Insured Person’s spouse must have had a history of infertility of at least 2 years’ duration or the infertility is associated with any of the following medical conditions:
   a. Endometriosis;
   b. Exposure in utero to diethylstilbestrol, commonly known as DES;
   c. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
   d. Abnormal male factors, including oligospermia, contributing to the infertility.

9. **Chiropractic Services** – manual manipulation Medically Necessary due to a Covered Sickness or Covered Injury.

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

11. **Accidental Injury Dental Treatment for Insured Person over age 18** - As the result of Injury. Routine dental care and treatment are not payable under this benefit.

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

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

**Medical Evacuation Expense** – If: 1. an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness; 2. that occurs while he or she is covered under the policy, We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or the Insured Person’s Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits. Payment of this benefit is subject to the following conditions: 1. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five or more consecutive days immediately prior to medical evacuation; 2. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation; 3. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable; 4. No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person’s insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination; 5. Evacuation of the Insured Person to his or her Home Country terminates any further
insurance under the Policy for the Insured Person; and 6. Transportation must be by the most direct and economical route.

**Repatriation Expense**: If the Insured Person dies while he or she is covered under the policy, We will pay a benefit. The benefit will be the necessary Usual and Reasonable charges for preparation, including cremation, and transportation of the remains to the Insured Person’s place of residence in his or her Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

**Clinical Trials for Cancer or Chronic Fatigue Syndrome Benefit**: We will pay the Usual and Reasonable expense incurred for medical treatment which an Insured Person receives as part of a clinical trial or study if: 1. The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome; and 2. The clinical trial or study is approved by: An agency of the National Institutes of Health as set forth in 42 U.S.C. § 281(b); A cooperative group; The Food and Drug Administration as an application for a new investigational drug; The United States Department of Veterans Affairs; or The United States Department of Defense. In the case of: 1. A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a Facility Authorized to Conduct Phase I Clinical Trials or Studies for the Treatment of Cancer; or 2. A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner; a. There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study; b. There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment; c. The clinical trial or study is conducted in this state; and d. The Insured Person has signed, before his or her participation in the clinical trial or study, a statement of consent indicating that he or she has been informed of, without limitation: (1) The procedure to be undertaken; (2) Alternative methods of treatment; and (3) The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks. Coverage for medical treatment is limited to: 1. Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the Insured Person; 2. The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under the Policy; 3. The cost of any routine health care services that would otherwise be covered under the Policy for an Insured Person participating in a Phase I clinical trial or study; 4. The initial consultation to determine whether the Insured Person is eligible to participate in the clinical trial or study; 5. Health care services required for the clinically appropriate monitoring of the Insured Person during a Phase II, Phase III or Phase IV clinical trial or study; and 7. Health care services which are required for the clinically appropriate monitoring of the Insured Person during a Phase I clinical trial or study and which are not directly related to the clinical trial or study. Particular medical treatment provided to an Insured Person under the Policy is not covered if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the Insured Person. In addition, coverage is not provided for: 1. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry. 2. Coverage for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device. 3. Health care services that are specifically excluded from coverage under the Policy, regardless of whether such services are provided under the clinical trial or study. 4. Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study. 5. Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a participant may incur. 7. Any expenses incurred by a person who accompanies the Insured Person during the clinical trial or study. 8. Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the Insured Person. 9. Any costs for the management of research relating to the clinical trial or study.

**Human Papillomavirus Vaccine Benefit**: We will pay the Usual and Reasonable expense incurred for administering the human papillomavirus vaccine to Insured Persons at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine. If this benefit is payable under the Preventive Services Benefit, it will be paid under one benefit only. It will be paid under the most favorable benefit.
**Autism Spectrum Disorder Benefit:** We will pay the Usual and Reasonable expense incurred for Screening for and Diagnosis of Autism Spectrum Disorders and for treatment of Autism Spectrum Disorders to Insured Persons under the age of 18 or, if enrolled in high school, until the person reaches the age of 22. Treatment of Autism Spectrum Disorders must be identified in a Treatment Plan. We may request a copy of and review the Treatment Plan. Benefits include Medically Necessary Habilitative or Rehabilitative Care, Prescription Care, Psychiatric Care, Psychological Care, Behavior Therapy or Therapeutic Care that is: 1. Prescribed for a person diagnosed with an autism spectrum disorder by a licensed Physician or licensed psychologist; and 2. Provided for a person diagnosed with an autism spectrum disorder by a licensed Physician, licensed psychologist, licensed behavior analyst or other provider that is supervised by the licensed Physician, psychologist or behavior analyst. Coverage provided is subject to the maximum benefit shown in the Schedule of Benefits. This benefit does not cover reimbursement to an early intervention agency or school for services delivered through early intervention or school services.

**Enteral Formulas Benefit:** We will pay the Usual and Reasonable expense incurred for: 1. Enteral formulas for use at home that are prescribed or ordered by a Physician as Medically Necessary for the treatment of Inherited Metabolic Diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat; and 2. Special Food Products which are prescribed or ordered by a Physician as Medically Necessary for the treatment of an Insured Person with an Inherited Metabolic Disease.

**Management and Treatment of Diabetes Benefit:** We will pay the Usual and Reasonable expense incurred for the management and treatment of diabetes including medication, equipment, supplies and appliances that are Medically Necessary for the treatment of diabetes. Coverage includes the self-management of diabetes including: 1. The training and education provided to the Insured Person after initially diagnosed with diabetes which is Medically Necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes; 2. Training and education which is Medically Necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the employee or member of the insured group which requires modification of his program of self-management of diabetes; and 3. Training and education which is Medically Necessary because of the development of new techniques and treatment for diabetes. Diabetes includes type I, type II, and gestational diabetes.

**Mastectomy and Reconstructive Surgery Benefit:** We will pay the Usual and Reasonable expenses incurred for the surgical procedure known as a mastectomy on the same basis as any other surgical procedure. In addition, We will cover Medically Necessary Reconstructive Surgery as follows: 1. Reconstruction of the breast on which the mastectomy has been performed; 2. Surgery and reconstruction of the other breast to produce a symmetrical structure; and 3. Prostheses and physical complications for all stages of mastectomy, including lymphedemas. The provision of services must be determined by the attending Physician and the Insured Person. If reconstructive surgery is begun within 3 years after a mastectomy, the amount of the benefits for that surgery must equal those amounts provided for in the Policy at the time of the mastectomy. If the surgery is begun more than 3 years after the mastectomy, the benefits provided are subject to all of the terms, conditions and exclusions contained in the Policy at the time of the Reconstructive Surgery.

**Temporomandibular Joint Syndrome Benefit:** We will pay the Usual and Reasonable expenses incurred for the Medically Necessary treatment of disorders of the temporomandibular joint. This Benefit does not cover those methods of treatment which are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints.

**Mental Illness Benefit:** We will cover treatment for Mental Illness on the same basis as any other Covered Sickness.

**Treatment of Substance Abuse Benefit:** We will pay the Usual and Reasonable expense incurred for the treatment of abuse of alcohol or drugs on the same basis as any other Covered Sickness.

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**Section 4 – Exclusions and Limitations**

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

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

1. Preventive medicines, serums or vaccines of any kind except as specifically provided under the Preventive Services Benefit.
2. Medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
3. dental treatment or treatment to the teeth including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person’s Sound, Natural Teeth or as covered under Pediatric Dental Benefit.
4. professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
5. services or supplies not necessary for the medical care of the Insured Person’s Injury or Sickness.
6. expenses for radial keratotomy or services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury or as otherwise covered under the Pediatric Vision Care benefit.
7. weak, strained or flat feet, corns, calluses or ingrown toenails.
8. surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness or as specifically covered under the Infertility Services benefit.
9. sleep disorders including the testing for same.
10. expenses covered under any Workers’ Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
11. charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
12. any expenses in excess of Usual and Reasonable charges.
13. loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
14. loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
15. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercolligate, intramural or club sports.
16. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
17. treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
18. services that are duplicated when provided by both a certified nurse-midwife and a Physician.
19. expenses payable under any prior Policy which was in force for the person making the claim.
20. expenses incurred after:
   a. The date insurance terminates as to the Insured Person;
   b. The Maximum Benefit for each Covered Injury or Covered Sickness has been attained; and
   c. The end of the Benefit Period specified in the Benefit Schedule.
21. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
22. charges incurred for acupuncture, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
23. expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.
24. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
   o For the purposes of this provision, Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
   o For the purposes of this provision, Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient’s appearance).
25. an Insured Person’s:
   o committing or attempting to commit a felony,
   o being engaged in an illegal occupation, or
   o participation in a riot.
26. elective abortions.
27. custodial care service and supplies.
28. expenses that are not recommended and approved by a Physician.
Section 5 – CLAIM PROCEDURE

In the event of Accident or Sickness the student should:

1. If at the College, report immediately to Health Services so that proper treatment can be prescribed or approved.
2. If away from the College, consult a doctor and follow his or her advice. Notify University of Nevada at Las Vegas within 90 days after the date of the Covered Injury or commencement of the Covered Sickness or as soon thereafter as is reasonably possible.
3. Secure a claim form from

CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5033
www.chpstudent.com

4. Complete the form.
5. Submit the claim form, complete with bills and receipts, to the Claims Administrator:

CIGNA
PO Box 188061
Chattanooga, TN 37422 – 8061
Electronic Payor ID: 62308
For information about the Cigna Prescription Drug Program please visit www.cigna.com.

6. Submit only one claim form for each Accident or Sickness.

Section 6 – Coordination of Benefits

If the Insured Person is insured under more than one group health plan, the benefits of the plan that covers the Insured Student will be used before those of a plan that provides coverage as a dependent Insured Person. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy on file with the Policyholder.

Section 7 - Appeals Procedure

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

Underwritten by:
National Guardian Life Insurance Company
as policy form # NBH-280 (2015) NV et al

Administered by:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5033
www.chpstudent.com
For a copy of the Company’s privacy notice you may go to:
www.consolidatedhealthplan.com/about/hipaa
or
Request one from the Health Office at your School
or
Request one from:
National Guardian Life Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502

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

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

Representations of this plan must
be approved by Us.

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

This Amendment makes the revisions listed below to the Policy and Certificate to which it is attached.

The definition of Accident is deleted in its entirety and replaced with the following:
**Accident** means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

The definition of Covered Injury is deleted in its entirety and replaced with the following:
**Covered Injury** means a bodily injury that is caused by the Accident directly and independently of all other causes. Coverage under the School’s policies must be in force on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

This Amendment is subject to all terms, conditions and provisions of the Policy/Certificate that are not inconsistent with it. Except as stated in this Amendment, it does not change or affect any other terms of the Policy and Certificate.

This Amendment takes effect on the same date as the Policy.


Kimberly A. Shaul
Secretary

Mark L. Solverud
President

NBH Amend Def
Value Added Services

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

**VISION DISCOUNT PROGRAM**
For Vision Discount Benefits please go to: www.chpstudent.com

**EMERGENCY MEDICAL AND TRAVEL ASSISTANCE**
Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-657-5033. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 or if you are in a foreign country, call collect at: 715.295.9311.** When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

**ASK MAYO CLINIC**
Students who enroll and maintain medical coverage in this insurance plan have access to a 24-hour nurse line administered by Ask Mayo Clinic. This program provides:
- Phone-based, reliable health information in response to health concerns and questions; and
- Assistance in decisions on the appropriate level of care for an injury or sickness.
Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.
Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.
This program is not a substitute for doctor visits or emergency response systems. *Ask Mayo Clinic* does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The *Ask Mayo Clinic* 24-hour nurse line toll free number will be on the ID card.