2019–2020 Student Health Insurance Plan

Policy No. 2019A4A20
Effective 8/1/19–8/1/20

Colorado School of Mines

Golden, CO

Administered by:

Academic Health Plans, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605
1-855-825-3985
www.ahpcare.com

Underwritten by:

National Guardian Life Insurance Company
Student Insurance Division
Commercial Travelers Building
70 Genesee Street
Utica, NY 13502
1-800-756-3702

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

As Policy Form No. NBH-280 (2019) CO

19-A4A20(Cert)

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

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-0826

CERTIFICATE OF STUDENT INSURANCE

Issued by
NATIONAL GUARDIAN LIFE INSURANCE COMPANY, PO BOX 1191, Madison, WI 53701-1191
(Herein referred to as "We", "Us", or "Our")

Please read this Certificate carefully for information on coverage, limitations, etc. Questions should be directed to the local agent Academic Health Plans at 1-855-825-3985.

If you need assistance resolving a complaint, please contact us at: 800-756-3702.

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 (2019) CO ("the Policy").

1. This Accident and sickness coverage begins on August 1, 2019, or the date of enrollment in the plan, whichever is later and ends on August 1, 2020 (Policy Year).
2. Benefits are payable during the Policy Year, subject to any Extension of Benefits
3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect until the end of the Policy Year for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.
4. The Policy provides benefits based on the type of health care provider the Insured Student selects. This Certificate provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

This Certificate includes a Pre-certification provision.

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SECTION 1 - SCHEDULE OF BENEFITS (Who Pays What)

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

1. On the date of occurrence of such Covered Injury; or
2. From the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of:

☒ the Policy Term (+ Extension of Benefits - when appropriate) ☐ Other

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

Non-Network Provider: Benefits are paid at 60% of the Usual and Reasonable charge.

Deductible:
Network: Individual $0
Non-Network: Individual $1,000

Hospital Inpatient Facility Copayment:
Network: $250
Non-Network: $750

Out-of-Pocket Expense Limit:
Network: Individual - $2,000
Non-Network: Individual - $4,000

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

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

PREFERRED PROVIDER ORGANIZATION:
To locate a Network Provider in Your area, consult Your Provider Directory or visit csm.myahpcare.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION; AND**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**

BENEFITS FOR COVERED INJURY/SICKNESS	NETWORK PROVIDER	NON-NETWORK PROVIDER
Inpatient Benefits		
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospital Miscellaneous Expenses for services & supplies, such as cost of	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies		
Hospital Room & Board Expenses	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Surgery: Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Habilitative Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Inpatient Services	Same as any other Covered Sickness	
Physician's Visits while Confined: (Includes a Specialist) Visit limited to one per day of Confinement	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Preadmission Testing	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Registered Nurse Services for private duty nursing while confined	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Rehabilitation Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Substance Use Disorder Inpatient Services	Same as any other Covered Sickness	
Outpatient Benefits		
Diagnostic X-ray Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Emergency Services Expenses	80% of *PPO Allowance* for Covered Medical Expenses Copayment: $100	80% of *PPO Allowance* for Covered Medical Expenses Copayment: $100
Outpatient Habilitative Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Home Health Care Expenses up to 28 hours per week	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospice Care Coverage	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
In Office Physician's Fees, including specialist, licensed registered nurse and licensed physician assistant	100% of PPO Allowance for Covered Medical Expenses Copayment: $25	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25
Laboratory Procedures (Outpatient)	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Outpatient Services	Same as any other Covered Sickness	
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

Outpatient Prescription Drugs	100% of PPO Allowance for Covered Medical Expenses after Copayment Generic Copayment: $15 Preferred Brand Copayment: $30 Brand Copayment: $60	Not Covered
Outpatient Surgery: Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Prostate Cancer Screening	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Rehabilitative Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Shots and Injections unless considered Preventive Services or otherwise covered under the Prescription Drug Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Skilled Nursing Facility Benefit Up to 100 Days per Policy Year	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Substance Use Disorder Outpatient Services	Same as any other Covered Sickness	
Urgent Care Centers or Facilities	80% of PPO Allowance for Covered Medical Expenses Copayment: $35	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $35
Other Benefits		
Accidental Injury Dental Treatment	80% of PPO Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses
Allergy Testing	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Ambulance Service	100% of PPO Allowance for Covered Medical Expenses	
Bariatric Surgery	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Chemotherapy and Radiation Therapy	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Chiropractic Care Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

Consultant Physician Services – when requested by the attending Physician	100% of PPO Allowance for Covered Medical Expenses Copayment: $25	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25
Dialysis	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Durable Medical Equipment	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Gender Reassignment	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Infertility Treatment	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Infusion Therapy	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mammography and Breast Cancer Screening	100% of PPO Allowance for Preventive Services	60% of Usual and Reasonable Charge for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	
Pediatric Dental Care Benefits Limited to two visits in a 12 month period Basic Restorative Oral Surgery Endodontics	100% of PPO Allowance for Preventive Services 50% of Usual and Reasonable Charge 50% of Usual and Reasonable Charge 50% of Usual and Reasonable Charge	50% of Usual and Reasonable for Preventive Services 50% of Usual and Reasonable Charge 50% of Usual and Reasonable Charge 50% of Usual and Reasonable Charge
Pediatric Vision Benefits Limited to 1 exam per Policy Year and 1 pair of prescribed lenses and frames or contact lenses	100% of PPO Allowance for Covered Medical Expenses for Preventive Services	50% of Usual and Reasonable Charge for Preventive Services
Physical, Occupational and Speech Therapy Subject to 20 visits per Policy Year	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Reconstructive Surgery	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Routine Adult Eye Exam Benefit	100% of PPO Allowance for Covered Medical Expenses for Preventive Services Copayment: $25.00	70% of Usual and Reasonable Charge for Preventive Services Copayment: $25.00
Routine Newborn Care	Same as any other Covered Sickness.	
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate sports up to $90,000 per Accident	90% of PPO Allowance for Covered Medical Expenses	70% of Usual and Reasonable Charge for Covered Medical Expenses
Student Health Center/Infirmary Expense	100% of Usual and Reasonable Charge for Covered Medical Expenses Deductible Waived	
Transplants	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Treatment for Temporomandibular Joint (TMJ) Disorders	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mandated Benefits		
Autism Spectrum Disorders Benefit (Insured Dependent Children Under Age 19)	Same as any other Covered Sickness up to the benefit maximums described in the Benefit	
Cervical Cancer Vaccination Benefit	Same as any other Preventive Service	

Cleft Lip and Cleft Palate Benefit	Same as any other Covered Sickness
Clinical Trials Benefit	Same as any other Covered Sickness
Diabetes Benefit	Same as any other Covered Sickness
Early Intervention Services Benefit Subject to maximum 45 visits per Policy Year	This benefit is not subject to a Deductible; Same as any other Covered Sickness
Hearing Aids for Minors Benefit	Same as any other Covered Sickness
Inherited Enzymatic Disorders Benefit	Same as any other Covered Sickness except that Medical Foods payable on same basis as other Prescription Drugs
Oral Anticancer Medication Benefit	Same as any other Covered Sickness
Prosthetic Devices Benefit	Same as any other Covered Sickness

SECTION 2 - ELIGIBILITY

All degree-seeking U.S. citizens and permanent resident students, regardless of credit hours, are required to purchase the Colorado School of Mines Student Insurance Plan. Students who can show proof of comparable coverage may be able to waive coverage. All International students enrolled in courses at the Colorado School of Mines are required to enroll in the SHIP. This requirement applies to all International Students (excludes International Scholars who have been awarded research, teaching or faculty appointments). International students who have government, embassy or US-based company sponsorships may be able to complete a waiver to opt out of the SHIP. (International policies MUST have a United States claims address and contact phone number to be approved for a waiver).

SECTION 3 – HOW TO ACCESS YOUR SERVICES AND OBTAIN APPROVAL OF BENEFITS

Pre-certification means the process of determining Medical Necessity before an Insured Person receives certain Treatments, services, or supplies. The Insured Person must notify the Plan Administrator and gain the Administrator's approval before the Insured Person receives any Treatment, service, or supply listed in the Policy. Pre-certification is not a guarantee the Treatment, service, or supply is an Eligible Expense under the Policy. Pre-certification is not required for Emergency Services.

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

The following inpatient benefits require Pre-certification:

1. All inpatient admissions to a Hospital, Skilled Nursing Facility, facility established primarily for the Treatment of Substance Use Disorder, or residential Treatment facility. The expected length of stay should be included in the notification;
2. All inpatient maternity care after the initial 48/96 hours;
3. Surgery;

Pre-certification is not required for:

- Medical Emergency or Urgent Care;
- Hospital Confinement for maternity care; or
- Obstetric or gynecological care when provided by a Network Provider; or
- Outpatient treatment.

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

The Insured Person's Physician will be notified of Our decision as follows:

1. For non-urgent admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the approved number of inpatient days;
2. For confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact the claims administrator before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone;
3. For any other covered services for which We require Pre-certification, We will contact the Physician in writing or by telephone regarding Our decision.

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

1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.

3. Notice of the availability, upon request of the Insured Person or his or her designee, of the clinical review criteria relied upon to make the Adverse Determination. The notice will specify any additional information needed by Our claims administrator to reach a decision on an appeal.

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

The Insured Person should contact his or her Physician with questions about any Pre-certification status.

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

Concurrent Review means review conducted during the Insured Person's stay or course of treatment in a facility, the office of a Physician, or other inpatient or outpatient health care setting.

Discharge planning means the process for determining, prior to discharge from a Hospital, the coordination and management of the care an Insured Person receives following discharge from the Hospital.

SECTION 4 – BENEFITS/COVERAGE (What is Covered)

Benefit Payments

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

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

Treatment of Covered Injury or Covered Sickness:
We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to 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. Use of a Network Provider, if any.

The following are shown in the Schedule of Benefits:

- Deductible
- Any specified benefit maximums
- Coinsurance percentages
- Copayment amounts
- Out-of-Pocket Expense Limits

The Covered Medical Expenses for an issued Policy will be only those listed in Covered Medical Expenses with all applicable Deductibles, Coinsurance and Copayment amounts, and maximums for each benefit shown in the Schedule of Benefits.

The total benefit payable for all Covered Medical Expenses resulting from Covered Injuries and Covered Sicknesses will never exceed the Maximum Benefit shown in the Schedule of Benefits. We will not pay for expenses incurred that do not meet the definition of Covered Medical Expense.

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

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

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

1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. 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.

Benefits for services received in a Network Provider Hospital from a Non-Network Provider will be paid at the Network level. The Insured Person's cost share will be the same as if the service was received from a Network Provider. The Insured Person will not be responsible for any additional charges from the Non-Network Provider.

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

Basic Injury and Sickness Benefit
If:

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

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

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

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

Benefits

1. **Accidental Injury Dental Treatment** as the result of Injury. Routine dental care and treatment are not payable under this benefit.

2. **Allergy Testing** for Insured Persons. This includes outpatient tests that the Insured Person needs such as PRIST, RAST, and scratch tests.

3. **Ambulance Service** for transportation to or from a Hospital by a licensed ambulance.

4. **Autism Spectrum Disorders Benefit** for the assessment, diagnosis, and outpatient treatment of Autism Spectrum Disorders for an Insured Person when Dependent coverage is included in this plan, or for newborn coverage for the first 31 days, benefits are available.

   Treatment for Autism Spectrum Disorders shall be for treatments that are Medically Necessary, appropriate, effective, or efficient and shall include the following:
   a. Evaluation and assessment services;
   b. Behavior training and behavior management and Applied Behavior Analysis, including but not limited to consultations, direct care, supervision, or treatment, or any combination thereof, for Autism Spectrum Disorders provided by Autism Services Providers;
   c. Habilitative or rehabilitative care, including, but not limited to, occupational therapy, physical therapy, or speech therapy, or any combination of those therapies. For a person who is also covered the Therapies for Congenital Defects and Birth Abnormalities Benefit that follows, the level of benefits for occupational therapy, physical therapy, or speech therapy shall exceed the limit of twenty visits for each therapy if such therapy is Medically Necessary to treat Autism Spectrum Disorders;
   d. Pharmacy Care and medication on the same basis as other Prescription Drugs;
   e. Psychiatric Care;
   f. Psychological Care, including family counseling; and
   g. Therapeutic care.

   Treatment for Autism Spectrum Disorders shall be prescribed or ordered by a Physician, including a psychologist.

   For purposes of this Benefit:
   Applied Behavior Analysis means the use of behavior analytic methods and research findings to change socially important behaviors in meaningful ways.

   Autism Services Provider means any person who provides direct services to a person with Autism Spectrum Disorder, is licensed, certified, or registered by the applicable state licensing board or by a nationally recognized organization, and who meets one of the following:
   a. Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology, is actively licensed by the Colorado medical board, and has at least one year of direct experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders;
   b. Has a doctoral degree in one of the behavioral or health sciences and has completed one year of experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders;

c. Has a master's degree or higher in behavioral sciences and is nationally certified as a "board certified behavior analyst" or certified by a similar nationally recognized organization;
d. Has a master's degree or higher in one of the behavior or health sciences, is credentialed as a related services provider, and has completed one year of direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with Autism Spectrum Disorders. Related services provider means a physical therapist, occupational therapist, or speech therapist.
e. Has a baccalaureate degree or higher in behavioral sciences and is nationally certified as a "board certified associate behavior analyst" or certified by a similar nationally recognized organization.

Autism Spectrum Disorders (ASD) includes the following neurobiological disorders: autistic disorder, asperger's disorder, and atypical autism as a diagnosis within pervasive developmental disorder not otherwise specified, as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, at the time of the diagnosis.

Pharmacy Care means medications prescribed by a Physician licensed by the Colorado medical board under Colorado law.

Psychiatric Care means direct or consultative services provided by a psychiatrist licensed by the Colorado medical board under Colorado law.

Psychological Care means direct or consultative services provided by a psychologist licensed by the state board of psychologist examiners pursuant to Colorado law.

Therapeutic Care means services provided by a speech therapist, an occupational therapist registered to practice occupational therapy pursuant to Colorado law or an Autism Services Provider. Therapeutic Care includes, but is not limited to, speech, occupational, and applied behavior analytic and physical therapies.

Treatment Plan means a plan developed for an Insured Person by an Autism Services Provider and prescribed by a Physician or a licensed psychologist pursuant to a comprehensive evaluation or reevaluation for an Insured Person consisting of the Insured Person's diagnosis; proposed treatment by type, frequency, and anticipated treatment; the anticipated outcomes stated as goals; and the frequency by which the Treatment Plan will be updated. The Treatment Plan shall be developed in accordance with the patient-centered medical home as defined in Colorado law.

6. **Bariatric Surgery** for Insured Persons when it is Medically Necessary.

7. **Cervical Cancer Vaccinations** for the full cost of an outpatient cervical cancer vaccination for all females for whom a vaccination is recommended by the advisory committee on immunization practices of the United States department of health and human services. Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

8. **Chemotherapy and Radiation Therapy** to treat or control a serious illness, as shown in the Schedule of Benefits.

9. **Child Health Supervision Services Benefit** when Dependent coverage is included in this plan, or for newborn coverage for the first 31 days, benefits are available for Insured Persons up to the age of thirteen (13). Child Health Supervision Services rendered during a periodic review shall only be covered to the extent such services are provided during the course of one visit by or under the supervision of a single Physician, Physician's assistant, or registered nurse.

   Child Health Supervision Services means those preventive services and immunizations required to be provided in basic and standard health benefit plans pursuant to Colorado law to Dependent children up to age thirteen. Such services shall be provided by a Physician or pursuant to a Physician's supervision or by a primary health care provider who is a Physician's assistant or registered nurse who has additional training in child health assessment and who is working in collaboration with a Physician.

   Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

10. **Chiropractic Care Benefit** for outpatient treatment of a Covered Injury or Covered Sickness and performed by a Physician. Coverage includes and evaluation; lab services and x-rays required for chiropractic services; and treatment of musculoskeletal disorders.

11. **Cleft Lip and Cleft Palate Benefit** for Medically Necessary care, supplies and treatment for a cleft lip or cleft palate or any condition or sickness which is related to or developed as a result of the cleft lip or cleft palate. Benefits include oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; orthodontic treatment; prosthodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment.

12. **Clinical Trials and Studies Benefit** for Routine Patient Care Costs due to an Insured Person participating in a Clinical Trial if:
    a. The Insured Person's treating Physician, who is providing covered health care services to the person under the Policy, recommends participation in the Clinical Trial after determining that participation in the Clinical Trial has the potential to provide a therapeutic health benefit to the Insured Person;
    b. The Clinical Trial or study is approved under the September 19, 2000, Medicare national coverage decision regarding Clinical Trials, as amended;
    c. The Insured Person care is provided by a certified, registered, or licensed health care provider practicing within the scope of his or her practice and the facility and personnel providing the treatment have the experience and training to provide the treatment in a competent manner;
    d. Prior to participation in a Clinical Trial or study, the Insured Person has signed a statement of consent indicating that the Insured Person has been informed of the procedure to be undertaken, alternative methods of treatment, the general nature and extent of the risks associated with participation in the Clinical Trial or study, the coverage provided by an individual or group health benefit plan will be consistent with the coverage provided in the Insured Person's health benefit plan, and all out-of-network rates will apply; and
    e. The Insured Person suffers from a condition that is disabling, progressive, or life-threatening.

    Benefits do not include:
    a. Any portion of the Clinical Trial or study that is paid for by a government or a biotechnical, pharmaceutical, or medical industry;
    b. Coverage for any drug or device that is paid for by the manufacturer, distributor, or provider of the drug or device;
    c. Extraneous expenses related to participation in the Clinical Trial or study including, but not limited to, travel, housing, and other expenses that a participant or person accompanying a participating Insured Person may incur;
    d. An item or service that is provided solely to satisfy a need for data collection or analysis that is not directly related to the clinical management of the participant;
    e. Costs for the management of research relating to the Clinical Trial or study; or
    f. Health care services that, except for the fact that they are being provided in a Clinical Trial, are otherwise specifically excluded from coverage under the Policy.

    For purposes of this Benefit:
    Clinical Trial means an experiment in which a drug or device is administered to, dispensed to, or used by one or more human subjects. An experiment may include the use of a combination of drugs as well as the use of a drug in combination with an alternative therapy or dietary supplement.

    Routine Patient Care Cost means all items and services that are a benefit under a health coverage plan that would be covered if the Insured Person were not involved in either the experimental or the control arms of a Clinical Trial; except the investigational item or service, itself; items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the Insured Person; items and services customarily provided by the research sponsors free of charge for any enrollee in the trial; routine costs in Clinical Trials that include items or services that are typically provided absent a Clinical Trial; items or services required solely for the provision of the investigational items or services, the clinically appropriate monitoring of the effects of the item of service, or the prevention of complications; and items or services needed for reasonable and necessary care arising from the provision of an investigational item or service, including the diagnosis or treatment of complications.

13. **Consultant Physician Services** when requested and approved by the attending Physician.

14. **Diabetes Benefit** for treatment of diabetes that shall include equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a Physician licensed to prescribe such items pursuant to Colorado law. Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

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

16. **Dialysis** for Medically Necessary outpatient treatment of acute renal failure and end-stage renal disease.

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

    Durable Medical Equipment includes Orthotic Devices which are intended to support, align, prevent, or correct movable parts of the body.
    Benefits are not payable for the following items:
    a. Corrective shoes for podiatric use and arch supports except for diabetic shoes;
    b. Dental devices and applicants except for treatment of cleft lip or cleft palate for newborn Dependents;
    c. Spare devices;
    d. Replacement for lost devices; or
    e. Repairs or replacements made necessary by misuse of the orthotic device.

18. **Early Intervention Services Benefit**, when Dependent coverage is included in this plan, or for newborn coverage for the first 31 days, benefits are available for outpatient Early Intervention Services delivered by a Qualified Early Intervention Service Provider to an Eligible Child from birth through age 2 who has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for intervention services under Colorado law. Early Intervention Services specified in an eligible child's IFSP shall qualify as meeting the standard for Medically Necessary health care services as used by private health insurance plans.

    Benefits are limited to the number of visits shown in the Schedule of Benefits.

    Qualified Early Intervention Service Providers that receive reimbursement under this Benefit shall accept such reimbursement as payment in full for services provided and shall not seek additional reimbursement from either the Insured Person or Us.

    Within ninety days after the Colorado Division of Insurance determines that a child is no longer an Eligible Child for purposes of this Benefit, it shall notify Us that the child is no longer eligible and that WE are no longer required to provide the coverage.

    Early Intervention Services shall be provided as specified in the eligible child's IFSP, and such services shall not duplicate or replace treatment for Autism Spectrum Disorders which are covered under the Autism Spectrum Disorders Benefit. Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

For purposes of this Benefit:
Early Intervention Services means services, as defined by the Colorado Division of Insurance in accordance with Part C, that are authorized through an Eligible Child's IFSP but that exclude non-emergency medical transportation; respite care; service coordination and assistive technology unless otherwise covered as Durable Medical Equipment.

Eligible Child means an Insured Person, from birth through two years of age, and who, as defined by the Colorado Division of Insurance, has significant delays in development or has a diagnosed physical or mental condition that has a high probability of resulting in significant delays in development or who is eligible for services pursuant to Colorado law.

Individualized Family Service Plan (IFSP) means a written plan developed pursuant to law that authorizes Early Intervention Services to an eligible child and the child's family. An IFSP shall serve as the individualized plan for an eligible child from birth through two years of age.

Part C means the early intervention program for infants and toddlers who are eligible for services under part C of the federal "Individuals with Disabilities Education Act", 20 U.S.C. sec. 1400 et seq.

Qualified Early Intervention Service Provider means a person or agency, as defined by the Colorado Division of Insurance in accordance with Part C, who provides Early Intervention Services and is listed on the registry of Early Intervention Service providers pursuant to Colorado law.

19. **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.

20. **Gender Reassignment Benefit** for Medically Necessary Treatment of Gender Dysphoria, including transition-related medical, surgical, and mental health care. All eligibility requirements must be met before the Insured Person undergoes surgical procedures.
    Requirements:
    a. Insured Person must be at least 18 years of age;
    b. Insured Person must provide documentation of persistent gender dysphoria;
    c. Provide proof that any significant medical or mental health conditions are well-controlled;
    d. Provide recommendation from qualified mental health professionals, at least one of which is acting in an evaluative role;
    e. Insured Person has undergone continuous hormone therapy as appropriate for the person's gender goal, unless the Insured has a medical issue or is otherwise unable to undergo hormone therapy.

    As used in this benefit**, Gender Dysphoria** means the Insured Person's conflict between the person's physical gender and the gender with which the person identifies. Gender dysphoria is not gender nonconformity, which is not matching the behaviors that are more socially expected of the person's gender assigned at birth.

    Plastic or Cosmetic surgery procedures are not covered under this benefit.

21. **Hearing Aids for Minors Benefit** for Medically Necessary hearing aids for Insured Persons under the age of 18 who have a hearing loss that has been verified by a Physician and by a licensed audiologist licensed. The hearing aids shall be medically appropriate to meet the needs of the child according to accepted professional standards. Coverage shall include the purchase of the following:
    a. Initial hearing aids and replacement hearing aids not more frequently than every five (5) years;
    b. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child;
    c. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

    Services provided under the Preventive Services Benefit will be payable under that benefit and not this Benefit.

22. **Home Health Care Expense** for outpatient Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a Skilled Nursing Facility would have been necessary. Benefits are subject to the limit shown in the Schedule of Benefits.

23. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, an Insured Person requires outpatient 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.

    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.

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

25. **Hospital Miscellaneous Expenses,** while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for inpatient 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.

26. **Hospital Room and Board Expense,** including general inpatient nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed. Benefits also include a private room rate when Medically Necessary.

27. **Infertility Treatment** is covered for the following outpatient services, including x-ray and laboratory procedures:
    a. Services for diagnosis and treatment of involuntary infertility; and
    b. Artificial insemination, except for donor semen, donor eggs and services related to their procurement and storage.

28. **Infusion Therapy** for the outpatient intravenous (into a vein) administration of nutrients, antibiotics, and other drugs and fluids when provided in the home.

29. **Inherited Enzymatic Disorders Benefit** for Medically Necessary treatment of Inherited Enzymatic Disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids as well as severe protein allergic conditions. Coverage includes, without limitation, the following diagnosed conditions: Phenylketonuria; maternal phenylketonuria; maple syrup urine disease; tyrosinemia; homocystinuria; histidinemia; urea cycle disorders; hyperlysinemia; glutaric acidemias; methylmalonic acidemia; propionic acidemia; immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis; eosinophilic disorders as evidenced by the results of a biopsy; and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract. Covered care and treatment of such conditions shall include Medical Foods for home use for which a Physician has issued a written, oral, or electronic prescription. There is no age limit on benefits for Inherited Enzymatic Disorders except for phenylketonuria.

The maximum age to receive benefits for phenylketonuria is twenty-one years of age; except that the maximum age to receive benefits for phenylketonuria for women who are of child-bearing age is thirty-five years of age.

For purposes of this Benefit:
Medical Foods means prescription metabolic formulas and their modular counterparts and amino acid-based elemental formulas, obtained through a pharmacy, that are specifically designated and manufactured for the treatment of inherited enzymatic disorders caused by single gene defects involved in the metabolism of amino, organic, and fatty acids and for severe allergic conditions, if diagnosed by a board-certified allergist or a board-certified gastroenterologist, for which medically standard methods of diagnosis, treatment, and monitoring exist. Such formulas are specifically processed or formulated to be deficient in one or more nutrients. The formulas for severe food allergies contain only singular form elemental amino acids. The formulas are to be consumed or administered enter ally either via tube or oral route under the direction of a Physician. This benefit shall not be construed to apply to cystic fibrosis Insured Persons or lactose- intolerant Insured Persons or soy-intolerant Insured Persons.

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

31. **Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. 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.

32. **Inpatient Habilitative Services and Devices** as described in the Schedule of Benefits. Benefits are payable for no less than twenty (20) visits per calendar year, per therapy for physical, speech, and occupational therapy for Inpatient Habilitative services.
Inpatient Habilitative services are visits are cumulative. Benefits are payable for up to sixty (60) visits for Inpatient Habilitative services per calendar year.
Other Habilitative services and devices include:
    a. cardiac habilitation services;
    b. pulmonary habilitation services;
    c. durable medical equipment – see the Durable Medical Equipment benefit for more detail;
    d. arm and leg prosthetics – see the Prosthetic Devices Benefit for more detail;
    e. inpatient and outpatient rehabilitative services – see Rehabilitation Services benefit for more detail;
    f. skilled nursing services for no less than 100 days of care annually;
    g. No less than two (2) months of inpatient rehabilitation annually, and no less than sixty (60) days;
    h. Autism spectrum disorder services – The limits included in this benefit do not apply to Autism Spectrum Disorder. Please see the Autism Spectrum Disorder benefit for more detail; and
    i. physical, occupational, and speech therapy for congenital defects for children up to age six (6).

33. **Outpatient Habilitative Services and Devices** as described in the Schedule of Benefits. Benefits are payable for no less than twenty (20) visits per calendar year, per therapy for physical, speech, and occupational therapy Outpatient Habilitative services.
Outpatient Habilitative services are visits are cumulative. Benefits are payable for up to sixty (60) visits for Outpatient Habilitative services per calendar year.
Other Habilitative services and devices include:
    a. cardiac habilitation services;
    b. pulmonary habilitation services;
    c. durable medical equipment – see the Durable Medical Equipment benefit for more detail;
    d. arm and leg prosthetics – see the Prosthetic Devices Benefit for more detail;
    e. No less than 100 days of skilled nursing services annually;
    f. No less than sixty (60) days of outpatient habilitative care annually;

g. Autism spectrum disorder services. The limits included in this benefit do not apply to Autism Spectrum Disorder. Please see the Autism Spectrum Disorder benefit for more detail; and
h. physical, occupational, and speech therapy for congenital defects for children up to age six (6).

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

35. **Mammography for Breast Cancer Screening** once per policy year for individuals possessing at least one risk factor:
    a. family history of breast cancer;
    b. Insured's age of forty years or older; or
    c. Genetic predisposition to breast cancer.

36. **Maternity Benefit** for maternity charges as follows:
    a. Routine prenatal care.
    b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the cesarean 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. If the 48 hours following delivery or the 96 hours following a cesarean section falls after 8 P.M., coverage shall continue until 8 A.M. the following morning.

       Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.
    c. **Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.
    d. **Physician-directed Follow-up Care** including:
       1) Physician assessment of the mother and newborn;
       2) Parent education;
       3) Assistance and training in breast or bottle feeding;
       4) Assessment of the home support system;
       5) Performance of any prescribed clinical tests; and
       6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

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

37. **Mental Health Disorder Inpatient Services Benefit** for inpatient treatment of Mental Health Disorders on the same basis as any other Covered Sickness, regardless of whether the Treatment is voluntary or court-ordered. See Treatment of Covered Injury or Covered Sickness.

38. **Mental Health Disorder Outpatient Services Benefit** for outpatient treatment of Mental Health Disorders on the same basis as any other Covered Sickness, regardless of whether the Treatment is voluntary or court-ordered . See Treatment of Covered Injury or Covered Sickness.

39. **Oral Anticancer Medication Benefit** for prescribed, orally administered anticancer medication that has been approved by the federal food and drug administration and is used to kill or slow the growth of cancerous cells on the same basis as We pay for cancer chemotherapy treatment. The orally administered medication shall be provided at a cost to the Insured Person not to exceed the coinsurance percentage or the Copayment amount as is applied to an intravenously administered or an injected cancer medication prescribed for the same purpose. A medication provided

shall be prescribed only upon a finding that it is Medically Necessary by the treating Physician for the purpose of killing or slowing the growth of cancerous cells in a manner that is in accordance with nationally accepted standards of medical practice, clinically appropriate in terms of type, frequency, extent site, and duration, and not primarily for the convenience of the Insured Person, Physician, or other health care provider.

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

41. **Outpatient Prescription Drugs** benefits are payable for Physician-prescribed drugs for an Insured Person when drugs are obtained from an outpatient pharmacy. We will pay up to the amount shown in the Schedule of Benefits for such medication. The medication must be Medically Necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription Drugs are subject to pre-certification.
    a. Contraceptive Coverage for all Outpatient Contraceptive Services and all outpatient contraceptive drugs and devices approved by the Food and Drug Administration (FDA) for any Insured Person. For purposes of this coverage, **Outpatient Contraceptive Services** means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods, including natural family planning, to prevent an unintended pregnancy.
    b. Off-Label Drug Treatments benefits are available if all of the conditions listed below are met. It is the responsibility of the prescribing Physician to submit documentation to Us that supports compliance with these conditions.
        i. The drug is approved by the FDA;
        ii. The drug is prescribed for the treatment of a life-threatening condition, including cancer, HIV or AIDS;
        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.

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

    d. **Investigational Drugs and Medical Devices** benefits are payable for a drug or device that is investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.
    e. **Tobacco Cessation Prescription and Over-the-Counter (OTC) drugs** benefits are payable for tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.studentplanscenter.com or call 1-800-756-3702.
    f. **Prescription Opioid Dependence Treatment** for a five-day supply of at least one of the Food and Drug Administration-approved drugs for the treatment of opioid dependence. Pre-certification is not required for this benefit. This benefit is limited to the first request within twelve-month period.

g. **Prescription Eye Drop Refills** if the request is made from a date at least as late as described below:
   i. At least 21 days for a 30-day supply;
   ii. At least 42 days for a 60-day supply;
   iii. At least 63 days for a 90-day supply.

   Benefits are payable for one addition bottle of prescription eye drops if:
   i. A bottle is requested by the Insured Person at the time the original prescription is filled; and
   ii. The original prescription states that one additional bottle is needed by the Insured for use in a day care center, school, or adult day program. The additional bottle may be filled once every three months.

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

43. **Outpatient Surgery Miscellaneous** (excluding non-scheduled surgery) surgery performed in a Hospital emergency room, trauma center, Physician's office, outpatient or ambulatory 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.

44. **Pediatric Dental Care Benefits** for covered Children up to age 19. We pay the expenses incurred for the following treatment or services. Diagnostic and Preventive procedures are limited to two outpatient dental exams in a 12 month period:
   a. Diagnostic and Preventive Procedures, as follows:
      i. Oral exams and evaluations;
      ii. Full mouth, intra-oral, and panoramic x-rays once in a 60 month period;
      iii. Bitewing x-rays once in a 12 month period;
      iv. Routine cleanings;
      v. Fluoride treatments;
      vi. Space maintainers for premature loss of deciduous (baby) posterior (back) teeth;
      vii. Sealants applied only to permanent molar teeth with the occlusal surfaces intact, no caries (decay), and/or with no restorations; and
      viii. Palliative treatment.

      Sealant benefits do not include any repair or replacement of a sealant on any tooth within 36 months of its application. Such repair or replacement done by the same dentist is considered included in the fee for the initial placement of the sealant.
   b. Basic Restorative services, as follows:
      i. Analgam fillings;
      ii. Resin and composite fillings;
      iii. Crowns;
      iv. Pin Retention; and
      v. Sedative fillings.
   c. Oral Surgery, consisting of extractions.
   d. Endodontics, consisting of:
      i. Surgical periodontal services; and
      ii. Root canal therapy.

45. **Pediatric Vision Benefits** for covered Children up to age 19.
    a. One outpatient routine eye exam, including dilation if professionally indicated, each year.
    b. One pair of prescription eyeglass lenses or contact lenses each year.
    c. One eyeglass frame each year.

46. **Physical, Occupational and Speech Therapy Services.** This benefit is limited to:
    a. 20 visits each for Physical Therapy, Occupational Therapy, and Speech Therapy for Rehabilitative services and for Habilitative services; and
    b. 20 visits each for Physical Therapy, Occupational Therapy, and Speech therapy for Rehabilitative services and for Habilitative services.

    The limits above do not apply to Physical, Occupational, and Speech Therapy services received under the Autism Spectrum Disorders Benefit.

    Therapy Services mean services administered with the expectation by the Insured Person's Physician that the therapy will result in practical improvement in the level of functioning.

    Occupational Therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.

    Speech Therapy is limited to treatment for speech impairments due to injury or illness.

47. **Physician's Visits while Confined** 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.

48. **Preadmission Testing** for routine inpatient 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.

49. **Prostate Cancer Screening** for annual screening for male Insured Persons who are age fifty or age forty years for Insured Persons who are in high-risk categories. Screening includes a prostate-specific antigen (PSA) blood test and a digital rectal examination.

50. **Prosthetic Devices Benefit** for Medically Necessary Prosthetic Devices that equal those benefits provided for under federal Medicare laws. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the Insured Person as determined by the Insured Person's treating Physician. Repairs and replacements of prosthetic devices are also covered unless necessitated by misuse or loss.

    For purposes of this Benefit:
    Prosthetic Device means an artificial device to replace, in whole or in part, an arm or leg.

51. **Reconstructive Surgery** is covered when a Physician determines it:
    a. Will correct significant disfigurement resulting from an injury or Medically Necessary surgery; or
    b. Will correct a congenital defect, disease or anomaly to produce major improvement in physical function; or
    c. Will treat congenital hemangioma (port wine stains) on the face and neck of Insured Persons 18 years and younger.

    We also cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas, following Medically Necessary removal of all or part of a breast.

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

53. **Inpatient Rehabilitative Services and Devices** as described in the Schedule of Benefits.. Benefits are payable for no less than twenty (20) visits per calendar year, per therapy for physical, speech, and occupational therapy for Inpatient Rehabilitative services. Other Rehabilitative services and devices include:
    a. cardiac rehabilitation services;

b. pulmonary rehabilitation services;
c. durable medical equipment – see the Durable Medical Equipment benefit for more detail;
d. arm and leg prosthetics – see the Prosthetic Devices Benefit for more detail;
e. inpatient and outpatient habilitative services – see Habilitation Services benefit for more detail;
f. skilled nursing services for no less than 100 days of care annually;
g. No less than two (2) months of inpatient rehabilitation annually, and no less than sixty (60) days;
h. Autism spectrum disorder services – see the Autism Spectrum Disorders benefit for more detail; and
i. physical, occupational, and speech therapy for congenital defects for children up to age six (6).

54. **Outpatient Rehabilitative Services and Devices** as described in the Schedule of Benefits. Benefits are payable for no less than twenty (20) visits per calendar year, per therapy for physical, speech, and occupational therapy Outpatient Rehabilitative services.
Outpatient Rehabilitative services are visits are cumulative. Benefits are payable for up to sixty (60) visits for Outpatient Rehabilitative services per calendar year.
Other Habilitative services and devices include:
a. cardiac rehabilitation services;
b. pulmonary rehabilitation services;
c. durable medical equipment – see the Durable Medical Equipment benefit for more detail;
d. arm and leg prosthetics – see the Prosthetic Devices Benefit for more detail;
e. No less than 100 days of skilled nursing services annually;
f. No less than sixty (60) days of outpatient rehabilitative care annually;
g. Autism spectrum disorder services. The limits included in this benefit do not apply to Autism Spectrum Disorder. Please see the Autism Spectrum Disorder benefit for more detail; and
h. physical, occupational, and speech therapy for congenital defects for children up to age six (6).

55. **Routine Adult Eye Exam Benefit** covers an outpatient wellness and refraction exam to determine the need for vision correction and to provide a prescription for eyeglasses. We also cover professional exams and the fitting of Medically Necessary contact lenses when a Physician prescribes them for a specific medical condition. The contact lenses, or eyeglass lenses and frames are not covered.

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

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

58. **Skilled Nursing Care Benefit** for up to 100 days per Policy Year in a licensed Skilled Nursing Facility. Inpatient services must be Medically Necessary. Confinement for custodial care is not covered.

60. **Sports Accident Expense Benefit** for an Insured Student as the result of covered sports accident while at play or practice of intercollegiate sports as shown in the Schedule of Benefits.

61. **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 exceed the amount shown in the Schedule of Benefits.

62. **Substance Use Disorder Inpatient Services Benefit** for inpatient treatment of Substance Use Disorders on the same basis as any other Covered Sickness, regardless of whether the Treatment is voluntary or court-ordered. See Treatment of Covered Injury or Covered Sickness.

63. **Substance Use Disorder Outpatient Services Benefit** for outpatient treatment of Substance Use Disorders on the same basis as any other Covered Sickness, regardless of whether the Treatment is voluntary or court-ordered. See Treatment of Covered Injury or Covered Sickness.

64. **Therapies for Congenital Defects and Birth Abnormalities Benefit** when Dependent coverage is included in this plan, or for newborn coverage for the first 31 days, benefits are available, benefits for Medically Necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for an Insured Person from the Insured Person's third birthday to the Insured Person's sixth birthday. The outpatient therapy visits shall be distributed as medically appropriate throughout the Policy Year, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

65. **Transplants** are covered on a limited basis as follows:
    a. Covered transplants are limited to: kidney transplants; heart transplants; heart-lung transplants; liver transplants; liver transplants for children with biliary atresia and other rare congenital abnormalities; small bowel transplants; small bowel and liver transplants; lung transplants; cornea transplants; simultaneous kidney-pancreas transplants; and pancreas alone transplants.
    b. Bone marrow transplants (autologous stem cell or allogenic stem cell) associated with high dose chemotherapy for germ cell tumors and neuroblastoma in children and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich syndrome.

66. **Treatment for Temporomandibular Joint (TMJ) Disorders** is covered when determined to be Medically Necessary by a Physician. Outpatient services that are covered include diagnostic x-rays, lab testing, physical therapy and surgery.

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

SECTION 5 – EXCLUSIONS/LIMITATIONS (What is Not Covered)

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.

- **International Students Only -** Eligible expenses within the Insured Person's Home Country or country of origin that would be payable or medical treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
- preventive medicines, serums or vaccines of any kind except as covered as Preventive Service or as specifically provided under the Policy.
- dental treatment for implants, denture repair and realignment, dentures and bridges, non-medically necessary orthodontia, and periodontics, except as specifically provided in the Schedule of Benefits.
- professional services rendered by an Immediate Family Member or anyone who lives with the Insured Person.

- services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
- expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
- any expenses in excess of Usual and Reasonable charges.
- 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.
- Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;
- 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.
- Injury sustained as the result of the Insured Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
- expenses incurred after:
    - The date insurance terminates as to the Insured Person; and
    - The end of the Benefit Period specified in the Benefit Schedule.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
- expenses for weight increase or reduction, except Medically Necessary bariatric surgery and hair growth or removal unless otherwise specifically covered under the policy.
- expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a covered accidental Injury.
- expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    - For the purposes of this provision**, Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    - For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.
- treatment to the teeth, including surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Policy definition of same. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
- an Insured Person's:
    - committing or attempting to commit a felony,
    - being engaged in an illegal occupation, or
    - participation in a riot.
- elective abortions.
- custodial care service and supplies.
- Non-human and artificial organs and their transplantation.

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

- A drug which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written;
- a drug which has an over-the-counter equivalent;
- Brand-Name Prescription Drugs with generic equivalents;
- weight control drugs;
- fertility drugs;
- vitamins, minerals, food supplements;
- sexual enhancements drugs;
- dietary supplements;

- cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or Treatment of acne except as specifically provided in the Policy;
- blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) prescription order per Policy Year;
- refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
- drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- purchased after the Insured Person's coverage terminates;
- a drug that is consumed or administered at the place where it is dispensed;
- any drug that the FDA determines is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- bulk chemicals;
- non-insulin syringes surgical supplies durable medical equipment/medical devices with the exception of diabetic blood monitors and kits;
- stimulants;
- repackaged products;
- blood components;
- single agent opioids;
- immunology products.

Limitations on Prescription Drugs:

- **Step Therapy** when medications for the Treatment of any Covered Injury or Covered Sickness are restricted for use by a step therapy or fail-first protocol, the prescribing Physician may request an override of the restriction from Us. An override of that restriction will be granted by Us when the Physician provides all necessary information to perform the override review. The information required is listed below.
    - The prescribing Physician can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy or fail-first protocol has been ineffective in the Treatment of the Insured Person's Covered Injury or Covered Sickness; or
    - Based on sound clinical evidence or medical and scientific evidence:
        - The prescribing Physician can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured Person and known characteristics of the drug regimen; or
        - The prescribing Physician can demonstrate that the preferred Treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the Insured Person.
- **Specialty Prescription Drugs** may be limited access or distribution and are limited to no more than a 30-day supply/subject to supply limits.
- **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist verify that the Outpatient Prescription Drug is used correctly and safely We rely on medical guidelines, FDA-approved recommendations, and other criteria developed by Us to set these quantity limits.
- **Tier Status** – The tier status of a Prescription Drug may change. Such changes may occur without prior notice to the Insured Person. However, if the Insured Person has a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug) We will notify the Insured Person of the change. When such changes occur, the out-of-pocket expense may change. The most current tier status is available at www.cigna.com or by calling the number on the Insured Person's ID card.
- **Supply Limits** – We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. The Insured Person is responsible for one (1) cost sharing amount for up to a 30-day supply.

COORDINATION OF POLICY'S BENEFITS WITH OTHER 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 Insured 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 6 – CLAIMS PROCEDURE (How to File a Claim)

In the event of an Accident or sickness, the Insured Person should:

1. If at Colorado School of Mines report immediately to Student Health Services so that proper treatment can be prescribed or approved.
2. If away from the University consult a doctor and follow his or her advice. Notify Colorado School of Mines within 90 days (or as soon as is reasonably possible) after the date of the Covered Injury or beginning of the Covered Sickness.
3. Secure a claim form from Cigna Healthcare or the Administrator's web site csm.myahpcare.com.
4. Complete the form.
5. Submit the claim form, complete with bills and receipts, to Cigna Healthcare.
6. Submit only one claim form for each event.

SECTION 7 – TERMINATION AND EXTENSION OF BENEFITS

Termination Dates: An Insured Person's insurance will terminate on the earliest of:

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

Reinstatement of Coverage Suspended during Periods of Active Duty: If an Insured Student is deployed by or called to active duty in the United States military and the Insured Student's coverage under the Policy terminates during the deployment or activation, We will reinstate the Insured Person when he or she returns to School as long as the Policy is still in force. Any waiting periods will be waived to the extent that coverage was in force under the Policy and such period was satisfied under the Policy before the deployment.

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

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

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.

SECTION 8 – DEFINITIONS

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

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.

Ambulance Service means transportation to a Hospital by a licensed 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.

Brand-Name Drug means a Prescription Drug which protected by a patent and is sold by a drug company under a specific name or trademark. The tier status is shown in the Formulary.

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, hyperemesis gravidarum, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

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

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

Covered Injury means a bodily injury that is caused by an Accident directly and independently of all other causes. Coverage under the School's policies must be inforce on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

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.

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

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

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 (other than Medically Necessary bariatric surgery), 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, breast reduction, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include 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.

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

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

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.

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/Civil Union Partner or the parent, child, brother or sister of the Insured Person or his or her spouse/Civil Union Partner.

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

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

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

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

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 Health Disorder means a condition or disorder, regardless of cause, which falls under any of the categories listed in the Mental Health Disorders section of the most recent version of:
1. The International Statistical Classification of Diseases and Related Health Problems;
2. The Diagnostic and Statistical Manual of Mental Disorders; or
3. The Diagnostic Classification of Mental Health and Developmental Disorders.

Autism Spectrum Disorders are included in this definition of Mental Health Disorders.
Benefits for the treatment of Mental Health Disorders will be no less extensive than the coverage provided for a Covered Sickness.

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

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

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

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

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

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

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

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

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

Skilled Nursing Facility means an institution that provides skilled nursing care under the supervision of a Physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.), and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

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

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

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

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

2. Inpatient care.

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

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

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

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

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

Underwritten by:
National Guardian Life Insurance Company
as policy form number NBH-280 (2019) CO

Administered by:
Academic Health Plans, Inc.
P.O. Box 1605 • Colleyville, TX 76034-1605
1-855-825-3985
www.ahpcare.com

For a copy of the Company's privacy notice, you may:
Visit: csm.myahpcare.com
Or
Request one from the Health Office at your School
Or
Request one from:
Academic Health Plans at 1-855-825-3985

(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 Certificate of Insurance 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.