

# Drew University

Madison, New Jersey

## Student Health Insurance Plan

Plan Year  
17/18

*Designed Exclusively for the Graduate  
Students of:*

### **Drew University**

Madison, NJ

2017 - 2018

*Underwritten by:*

National Guardian Life Insurance Company  
Madison, WI

Policy Number: 2017I5B31

Group Number: ST0834SH

Effective: 8/15/2017 - 8/15/2018



**Administered by:**

Consolidated Health Plans

2077 Roosevelt Ave | Springfield, MA



ST0834SH-1718(Bro.)

## WHERE TO FIND HELP

| For Questions About:   | Please Contact:   |
|--|---|
| Health Services  | <b>Drew University Health Services</b><br>36 Madison Ave<br>Madison, NJ 07940<br>(973) 408-3414<br><a href="mailto:Health@drew.edu">Health@drew.edu</a> or visit our website at<br><a href="http://www.drew.edu/health">www.drew.edu/health</a> |
| Servicing Broker   | <b>University Health Plans</b><br>15 Pacella Park Drive<br>Randolph, MA 02368<br>800-437-6448<br><a href="http://www.universityhealthplans.com">www.universityhealthplans.com</a>   |
| Insurance Benefits<br>Preferred Provider Listings<br>Claims Processing<br>ID Card Requests | <b>Consolidated Health Plans</b><br>2077 Roosevelt Avenue<br>Springfield, Massachusetts 01104<br>(877) 657-5030<br><a href="http://www.chpstudent.com">www.chpstudent.com</a>   |
| Preferred Provider Listings  | <b>Cigna PPO</b><br><a href="http://www.cigna.com">www.cigna.com</a>  |
| Prescription Drug Providers  | <b>Cigna PBM</b><br><a href="http://www.cigna.com">www.cigna.com</a>  |

## EFFECTIVE DATES AND COSTS

|                | Annual*<br>08/15/2017 – 08/15/2018 | Fall*<br>08/15/2017 – 01/15/2018 | Spring*<br>01/15/2018-08/15/2018 |
|----------------|------------------------------------|----------------------------------|----------------------------------|
| <b>Student</b> | <b>\$4,236</b>                     | <b>\$1,755</b>                   | <b>\$2,481</b>                   |

\*The above rates include an administrative fee.

The Policy is renewed as a new policy for the term August 15, 2017 to August 15, 2018 as Policy Number 201715B31. All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

## IMPORTANT INFORMATION FROM DREW UNIVERSITY

Drew University requires all full-time college students to carry medical insurance. Students should enroll or waive the insurance plan before arriving on campus in the Fall, please see page 8 of this document for instructions to do this. Students will automatically be billed for this plan through Drew's Student Accounts Office should they fail to submit a waiver application. The Fall waiver is an annual waiver; only new students may enroll in the Spring semester.

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

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

The student health insurance plan described in this brochure has been designed to complement the services that are available on-campus, and will provide coverage for eligible expenses for off-campus referrals or Hospitalizations. Students enrolled in this insurance plan will not be billed for allergy shots, laboratory tests, and well-woman services that are obtained on campus (except international travel advisory/vaccines). This plan will meet the needs of most students. Optional plans for new graduate continuation coverage are also available. Call University Health Plans directly for more information (800) 437-6448, or contact them at: [www.universityhealthplans.com](http://www.universityhealthplans.com).

### DREW UNIVERSITY HEALTH SERVICES

Students do not have to enroll in the student insurance plan in order to receive care at the Drew University Health Service. On-campus services include:

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

Health Service Hours: (regular semesters)

Monday - Thursday 9 AM - 8 PM

Friday 9 AM - 5 PM

Saturday 10 AM - 2 PM

Sunday 2 PM

Limited hours during January & summers

For more information about on-campus services contact:

Drew University Health Service

36 Madison Avenue

Madison, NJ 07940

(973) 408-3414 [health@drew.edu](mailto:health@drew.edu)

Or visit our website at [www.drew.edu/health](http://www.drew.edu/health)

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

#### COVERAGE

1. Accident and Sickness coverage begins on August 15, 2017, or the date of enrollment in the plan, whichever is later and ends August 15, 2018 (Policy Year).
2. Benefits are payable during the Policy Year, subject to any Extension of Benefits.
3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Year for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.

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

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2013) NJ ("the Policy"). This Certificate is governed by the state of New Jersey.

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#### Section 1 — Definitions

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

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

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

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

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

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

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

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

**Copayment** means the amount of 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 engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

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

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

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

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

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

**Developmental Disability** as defined in the New Jersey Developmentally Disabled Rights Act means a severe, chronic disability of a person which: 1. is attributable to a mental or physical impairment or combination of mental or physical impairments; 2, is manifested before age 22; 3, is likely to continue indefinitely; 4, results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and 5. reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated. Developmental Disability includes but is not limited to severe disabilities attributable to mental retardation, autism, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met. Behavioral Interventions Based on ABA are interventions or strategies based upon learning theory that are intended to improve socially important behavior of an individual using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements, including the empirical identification of functional relations between behavior and environmental factors. Behavioral Intervention strategies based on ABA include, but are not limited to: (1. chaining; (2. functional analysis; (3. functional assessment; (4. functional communication training; (5. modeling, including video modeling (also known as imitation training); (6. procedures designed to reduce challenging and dangerous behaviors (e.g., differential reinforcement, extinction, time out, and response cost); (7. prompting; and (8. reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization. Related Structured Behavioral Programs are services delivered by a qualified practitioner that are comprised of multiple intervention strategies (that is, behavioral intervention packages) based upon the principles of ABA. These packages may include but are not limited to: (1. activity schedules; (2. discrete trial instruction; (3. incidental teaching; (4. natural environment training; (5. picture exchange communication system; (6. pivotal response treatment; (7. script and script-fading procedures; and (8. self-management.

**Domestic Partner** means a person who satisfies the criteria for a domestic partnership. A domestic partnership shall be established when all of the following requirements are met: 1. Both persons have a common residence and are otherwise jointly responsible for each other's common welfare as evidenced by joint financial arrangements or joint ownership of real or personal property, which shall be demonstrated by at least one of the following: a. a joint deed, mortgage agreement or lease; b. a joint bank account; c. designation of one of the persons as a primary beneficiary in the other person's will; d. designation of one of the persons as a primary beneficiary in the other person's life

insurance policy or retirement plan; or e. joint ownership of a motor vehicle; 2. Both persons agree to be jointly responsible for each other's basic living expenses during the domestic partnership; 3. Neither person is in a marriage recognized by New Jersey law or a member of another domestic partnership; 4. Neither person is related to the other by blood or affinity up to and including the fourth degree of consanguinity; 5. Both persons are of the same sex or mixed-gender and both are 62 years of age or older; 6. Both persons have chosen to share each other's lives in a committed relationship of mutual caring; 6. Both persons file jointly an Affidavit of Domestic Partnership with the local registrar; and 8. Neither person has been a partner in a domestic partnership that was terminated less than 180 days prior to the filing of the current Affidavit of Domestic Partnership, except that this prohibition shall not apply if one of the partners died; and, in all cases in which a person registered a prior domestic partnership, the domestic partnership shall have been terminated in accordance with New Jersey law.

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

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

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

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

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: 1. placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2. serious impairment to bodily functions; or 3. serious dysfunction of a bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where: 1. there is inadequate time to effect a safe transfer to another hospital before delivery; or 2. the transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

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

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

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

**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 rehabilitatory care; or 3. Facilities for the aged, drug addicts or alcoholics.

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

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

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

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

**Insured Person** means You or Your dependent while insured under the policy.

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

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

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

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

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

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

**Medical Necessity or Medically Necessary** means or describes a health care service that a Physician, exercising his or her prudent clinical judgment, would provide to an Insured Person for the purpose of evaluating, diagnosing, or treating a Covered Sickness, Covered Injury, disease, or its symptoms and that is: 1. in accordance with the generally accepted standards of medical practice; 2. clinically appropriate, in terms of type, frequency, extent, site, and duration; 3. considered effective for the Insured Person 's Covered Sickness, Covered Injury, or disease; 4. not primarily for the convenience of the Insured Person or the Physician ; and 5. not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Insured Person 's Covered Sickness, Covered Injury, or disease.

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

**Out-of-pocket Expense Limit** means the 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 registered nurse, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician. The term Physician does not mean any person who is an Immediate Family Member.

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

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

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

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

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

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

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

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

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

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

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

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

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

## **Section 2 – Eligibility, Enrollment and Termination**

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

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

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

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

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

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



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

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

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

**Continuous Coverage:** Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under the policy:

1. When premium payment is received either in Our Home Office or by Our Agent or the Plan Administrator; and
2. Premium is received within the Enrollment Period specified in the Insurance Information Schedule.

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

### Section 3— BENEFITS

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

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

**Treatment of Covered Injury or Covered Sickness:** We will pay benefits for the Usual and Reasonable Charges for Covered Medical Expenses that are incurred by the Insured Person due to a Covered Injury or Covered Sickness. Benefits are also provided for Preventive Services and female contraceptives as described in Section VI – DESCRIPTION OF BENEFITS. Benefits payable are subject to: 1. The Maximum Benefit for all Covered Injury and Covered Sickness combined; 2. The Maximum Benefit for all services; 3. Any specified benefit maximum amounts; 4. Any Deductible amounts; 5. Any Coinsurance amount; 6. Any Copayments; 7. the Exclusions and Limitations provision.

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

**See NBH(EHB) NJ 2014 rev. 3/15) at the end of this Certificate.**

### **Inpatient Benefits**

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

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

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

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

**Physician's Visits while Confined** - We will pay the expenses incurred for Physician's visits not to exceed one visit per day. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

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

**Physical Therapy while Confined** - We will pay the expenses incurred for physical therapy when prescribed by the attending Physician.

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

### **Outpatient Benefits**

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

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

**Physical Therapy** - When prescribed by the attending Physician, limited to one visit per day.

**Emergency Services Expenses** - 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.

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

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

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

**Prescription Drugs** – 1. We will pay the expenses incurred for medication for which a Physician’s written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made. 2. Off-Label Drug Treatments  
When prescription drugs are provided as a benefit of the issued Policy, provides benefits for expenses incurred in prescribing a drug for a treatment for which the drug has not been approved by the Food and Drug Administration if the drug is recognized as being medically appropriate for the specific treatment for which it has been prescribed: a. in one of the following established reference compendia: the American Medical Association Drug Evaluations; the American Hospital Formulary Service Drug Information; the United States Pharmacopoeia Drug Information; or b. it is recommended by a clinical study or review article in a major peer-reviewed professional journal. Coverage is not provided for any experimental or investigational drug or any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed. Benefits also include Medically Necessary services associated with the administration of the drug. 3. This benefit also covers the purchase of prescription female contraceptives on the same basis as other outpatient prescription drugs. Prescription female contraceptives includes any drug or device used for contraception by a female Insured Person, which is approved by the federal Food and Drug Administration for that purpose, that can only be purchased in New Jersey with a prescription written by a Physician licensed or authorized to write prescriptions, and includes, but is not limited to, birth control pills and diaphragms. A religious School may request, and We shall grant, an exclusion under the Policy for female contraceptives if the benefit conflicts with the religious schools bona fide religious beliefs and practices. The School shall provide written notice thereof to prospective Insured Persons and Insured Persons. A religious School is an elementary, secondary school, college or university that is controlled, operated or principally supported by a church or by a convention or association of churches as defined in 26 U.S.C. § 3121(w)(3)(A), and that qualifies as a tax-exempt organization under 26 U.S.C. § 501(c)(3).

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

**Hospice Care Coverage** - When, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare. As used in this benefit:

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

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

#### **Other Benefits**

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

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

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

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

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

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

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

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

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

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

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

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

**Medical Evacuation Expense** - If an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness that occurs while he or she is covered under the policy, We will pay the

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

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

#### **Mandated and Must Offer Benefits for New Jersey**

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

Mandated Benefits for New Jersey:

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

**Treatment of Autism or Other Developmental Disabilities** - We will pay the Usual and Reasonable expenses incurred for: 1. The screening and diagnosing of Autism or another Developmental Disability; 2. Medically Necessary physical therapy, occupational therapy and speech therapy services prescribed through a treatment plan for the treatment of Autism or another Developmental Disability; 3. Medically Necessary behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) and Related Structured Behavioral Programs for treatment of Autism in an Insured Person under 21 years old if administered directly by or under the direct supervision of an individual who is credentialed by the National Behavior Analyst Certification Board as either: a) Board Certified Behavior Analyst - Doctoral (BCBA-D); or b) a Board Certified Behavior Analyst (BCBA); and 4. Expenses incurred by an Insured Person for services under #2 & #3 above when obtained through the New Jersey Early Intervention System when participating in an individualized family service plan through a Family Cost Share. Coverage will be provided without consideration of whether the services are restorative or have a restorative effect. The benefits will be paid on the same basis as any other Covered Sickness but the total number of visits that an Insured Person may make to a provider of Behavioral Interventions under this provision will not be limited. The maximum benefit amount for an Insured Person is shown in the Schedule of Benefits.

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

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

**Therapeutic Treatment of Inherited Metabolic Diseases** - We will pay the Usual and Reasonable expenses incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods and low protein modified food products, when diagnosed and determined to be Medically Necessary by the Insured's Physician.

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

peripheral stem cell transplants.

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

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

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

**Biologically Based Mental Illness Benefit** - We will pay the Usual and Reasonable expenses incurred for the treatment of a Biologically Based Mental Illness on the same basis as for any other Covered Sickness.

As it pertains to this benefit, **Biologically Based Mental Illness** means a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the Insured Person with the Illness. Biologically Based Mental Illness includes, but is not limited to the following: 1. Schizophrenia; 2 Schizoaffective disorder; 3. Major depressive disorder; 4. Bipolar disorder; 5. Paranoia and other psychotic disorders; 6. Obsessive-compulsive disorder; or 7. Panic and pervasive developmental disorder.

**Orthotic or Prosthetic Appliances Benefit** - We will pay the Usual and Reasonable expenses incurred in obtaining an orthotic or prosthetic appliance from any licensed orthotist or prosthetist, or any certified pedorthist, as determined Medically Necessary by the Insured Person's Physician. Reimburse for orthotic and prosthetic appliances will be at the same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule. Benefits will be provided to the same extent as for any other medical condition under the policy.

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

**Home Health Care Benefits** - We will pay benefits for the following Covered Medical Expenses when the Insured Person requires Home Health Care. Covered Expenses under this benefit are limited to the following: 1 Home Health Care Visits - We will pay the Usual and Reasonable expenses incurred for up to 60 Home Health Care Visits in any continuous 12 months period; and 2. Other Home Health Care Services - We will pay the charges for other Home Health Care Services, as defined, not to exceed the amount the Policy would have paid if the Insured Person had been hospitalized.

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

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

**Treatment of Diabetes** - We will pay the following benefits: 1. Equipment and Supplies -We will pay the Usual and Reasonable expenses incurred if an Insured incurs expenses for any of the following equipment and supplies used in the treatment of diabetes: a) blood glucose monitors and blood glucose monitors for the legally blind; b) data management systems; c) test strips for glucose monitors and visual reading and urine testing strips; d) insulin,

injection aids, cartridges for the legally blind, syringes, insulin pumps and e) appurtenances thereto; f) insulin infusion devices; and oral agents for controlling blood sugar.

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

**Alcoholism Treatment Benefit** - If the Insured Person requires treatment for alcoholism, We will pay the Usual and Customary charges for such treatment to the same extent as We would pay for any other covered Sickness. Treatment must be prescribed by an M.D. We will provide benefits for the treatment of alcoholism as follows: 1. inpatient or outpatient care in a licensed Hospital; 2. treatment at a detoxification facility licensed and approved by the Division of Alcohol; and 3. confinement as an inpatient or outpatient at a licensed, certified, or state approved residential treatment facility, under a program that meets minimum standards of care equal to those prescribed by the Joint Commission on Hospital Accreditation. Such treatment or programs must be certified by the Department of Mental Health, accredited by a nationally recognized organization, or licensed by the State of New Jersey. The total number of benefit days under this provision may not exceed the total number of benefit days provided for any other Sickness under the contract. Treatment or confinement at any facility will not preclude further or additional treatment at any other eligible facility.

**Mammography Benefit** - We will pay the Usual and Customary charges for expenses incurred in conducting: one baseline mammogram examination for female Insured Persons who are at least 35 but less than 40 years of age; a mammogram examination every year for female Insured Persons age 40 and over; and, in the case of a female Insured Person woman who is under 40 years of age and has a family history of breast cancer or other breast cancer risk factors, a mammogram examination at such age and intervals as deemed Medically Necessary by the woman's Physician. If benefits are also payable under the Preventive Services Benefit or the Health Wellness Promotion Benefit, We will pay under only one benefit, the more favorable benefit.

**Diagnosis and Treatment of Fertility:** We will pay the Usual and Customary and Medically Necessary expenses incurred for the diagnosis and treatment of Infertility. Such coverage includes, but is not limited to the following services related to infertility: 1. Diagnosis and diagnostic tests; 2. Medications; 3. Surgery; 4. In vitro fertilization; 5. Embryo transfer; 6. Artificial insemination; 7. Gamete intra fallopian transfer; 8. Zygote intra fallopian transfer; 9. Intracytoplasmic sperm injection; and 10. Four completed egg retrievals per lifetime of the Insured Person.

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

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

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

the benefit payable.

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

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

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

**Health Wellness Examinations Benefit:** We will pay the Usual and Reasonable charges for expenses incurred while coverage is in effect under the Policy in a health promotion program through health wellness examinations and counseling. The program shall include, but not be limited to, the following tests and services: 1. For all Insured Persons 20 years of age and older, annual tests to determine blood hemoglobin, blood pressure, blood glucose level, and blood cholesterol level or, alternatively, low-density lipoprotein (LDL) level and blood high-density lipoprotein (HDL) level; 2. For all Insured Persons 35 years of age or older, a glaucoma eye test every five years; 3. For all Insured Persons 40 years of age or older, an annual stool examination for presence of blood; 4. For all Insured Persons 45 years of age or older, a left-sided colon examination of 35 to 60 centimeters every five years; 5. For all Insured Persons 20 years of age or older, a pap smear pursuant to the provisions of section 4 of P.L. 1995, c. 415 (C. 17B:27-46.1n); 6. For all women 40 years of age or older, a mammogram examination pursuant to the provisions of section 5 of P.L. 1991, c. 279 (C. 17B:27-46.1f); 7. For all adults, recommended immunizations; and 8. For all persons 20 years of age or older, an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including, but not limited to, smoking control, nutrition and diet recommendations, exercise plans, lower back protection, weight control, immunization practices, breast self-examination, testicular self-examination and seat belt usage in motor vehicles. If benefits are also payable under the Preventive Services Benefit or the Prostate Screening Benefit or the Mammography Benefit, the benefit will be payable only under one benefit – the most favorable benefit. The maximum benefit amount for this benefit is shown in the Schedule of Benefits.

#### **Section 4 – Exclusions and Limitations**

**Exclusion Disclaimer:** Any exclusion in conflict with the Patient Protection and Affordable Care Act or any state imposed requirements will be administered to comply with the requirements of the Act. The policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the policy and as shown in the Schedule of Benefits.

1. **International Students Only** - Eligible expenses within Your Home Country or country of origin that would be payable or medical treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
2. preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.
3. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as provided in the Schedule of Benefits.
4. dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to Your Sound, Natural Teeth.
5. professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
6. services or supplies not necessary for the medical care of an Injury or Sickness except as specifically covered under any of the preventive benefits provided under the Policy.
7. services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury or except as specifically provided under the Policy.
8. weak, strained or flat feet, corns, calluses or ingrown toenails.
9. treatment or removal of acne, or sleep disorders including the testing for same.
10. expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.



11. charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
12. any expenses in excess of Usual and Reasonable charges.
13. loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
14. loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Insurance Information Schedule.
15. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any intercollegiate, intramural or club sports.
16. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sports;
17. treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
18. Injury sustained as the result of Your operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
19. expenses incurred after: a) The date insurance terminates as to the Insured Person
20. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
21. expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.
22. expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a Covered Injury.
23. skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
24. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery. For the purposes of this provision Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible and Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance).
25. an Insured Person's: a) committing or attempting to commit a felony; b) being engaged in an illegal occupation, or c. participation in a riot.
26. Elective abortions in excess of the amount shown in the Schedule of Benefits.
27. custodial care service and supplies.
28. expenses that are not recommended and approved by a Physician.

#### **Section 5 –CERTIFICATE PROVISIONS**

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

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

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

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

**Payment of Claims:** Benefits will be paid to the Insured Person. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is

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

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

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

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

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

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

## Section 6 – Coordination of Benefits

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

## Section 7 - Appeals Procedure

For purposes of this Section, the following definitions apply:

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

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

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

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

### Internal Review Procedure

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

or his or her office at any time.

2. A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Benefit Determination. The Insured Person does not have the right to attend, or have an authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, may: a. review all documents related to the claim and submit written comments and issues related to the denial; and b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

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

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

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

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

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

#### **Expedited reviews of grievances involving an Adverse Benefit Determination**

We shall provide expedited review of a grievance involving an Adverse Benefit Determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility. The Insured Person or the Insured Person's authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, shall request an expedited review orally or in writing. We will appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the Adverse Benefit Determination. The clinical peer or peers shall not have been involved in making the initial Adverse Benefit Determination. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the Insured Person or, if applicable, the Insured Person's authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, and Us by telephone, facsimile or the most expeditious method available. An expedited review decision shall be made and the Insured Person or, if applicable, the Insured Person's authorized representative, including a Physician acting on behalf of the Insured Person with the Insured Person's consent, shall be notified of the decision within seventy-two (72) hours after the receipt of the request for the expedited review. If the expedited review is of a grievance involving an Adverse Benefit Determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the Insured Person until the Insured Person has been notified of the determination.

### **If the Insured Person Disagrees with Our Internal Review Determination**

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

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

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

### **External Review Procedure**

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an Adverse Benefit Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply. We shall notify the Insured Person in writing of the Insured Person's right to request an external review at the time the We send written notice of: a.) An Adverse Benefit Determination upon completion of the Our utilization review process described above; or b.) A Final Internal Adverse Benefit Determination. An external review may be requested within 60 days after the Insured Person receives Our adverse benefit determination. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.
2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person, including a Physician acting on behalf of the Insured Person with the Insured Person's consent.
3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.
4. We will review the request and if it is:
  - a. Complete we will initiate the external review and notify the Insured Person of:
    - i. The name and contact information for the assigned independent review organization or the Commissioner of Banking and Insurance as applicable for the purpose of submitting additional information; and
    - ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or Commissioner of Banking and Insurance to consider when conducting the external review. However, this doesn't apply to expedited request or external reviews that involve an experimental or investigational treatment.
  - b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.
5. We will not afford the Insured Person an external review if:
  - a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
  - b. The Insured Person has failed to exhaust Our internal review process; or
  - c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

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

- a. The reason for the denial; and
  - b. That the denial may be appealed to the Commissioner of Insurance.
6. For an expedited review: the Insured Person may make a request for an expedited external review after receiving an Adverse Benefit Determination if:
    - a. The Insured's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time frame of an expedited internal review.
    - b. The Insured Person's treating physician certifies that the Adverse Benefit Determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person, or would jeopardize the

Insured Person's ability to regain maximum function, if treated after the time frame of a standard external review. or

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

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

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

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

**Underwritten by:**  
**National Guardian Life Insurance Company**  
**Madison, WI**  
**As Policy form: NBH-280 (2013) NJ et al**

**Administered by:**  
**CONSOLIDATED HEALTH PLANS**

2077 Roosevelt Ave  
Springfield, MA 01104  
Toll Free (877) 657-5030

[www.chpstudent.com](http://www.chpstudent.com)

or email us at: [customerservice@consolidatedhealthplan.com](mailto:customerservice@consolidatedhealthplan.com)

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

[www.consolidatedhealthplan.com/about/hipaa](http://www.consolidatedhealthplan.com/about/hipaa)

or

Request one from the Health Office at your School

or

Request one from:

**National Guardian Life Insurance Company**

**C/O Privacy Officer**

**70 Genesee Street**

**Utica, NY 13502**

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

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

***Representations of the Plan must be approved by the Company.***

**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.**

### ESSENTIAL HEALTH BENEFIT RIDER – NEW JERSEY

The Policy/Certificate to which this Rider is attached is amended as follows:

A. The Schedule of Benefits is deleted from Policy NBH-280 (2013) NJ and from Certificate NBHCert-280(2013)NJ. The Schedule of Benefits is replaced in the Policy and Certificate with the attached Schedule of Benefits to reflect Essential Health Benefits, not subject to annual or lifetime dollar limits. If additional care, treatment or services are added to the list of Essential Health Benefits by a governing authority, the Policy and Certificate benefits will be amended to comply with such change.

B. The Eligibility and Participation Basis provision is amended by adding the following to the end of the first paragraph:

To be eligible for coverage under the policy/Certificate, a Student must:

1. meet the enrollment requirements stated in the Insurance Information Schedule; and
2. pay the required premium; and
3. attend classes for at least the first 31 days of the period for which premium has been paid.

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

C. The "Definitions" provision is amended as follows:

The definition of Covered Sickness is deleted and replaced with the following:

**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.

The following definitions are added:

**Essential Health Benefits** - mean benefits that are defined as such by the Secretary of Labor in the following general categories, and the items and services covered within the categories:

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

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

**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.

- D. The "Description of Benefits" section is amended as follows:
1. Under Treatment of Covered Injury or Covered Sickness, item 1, Maximum Benefit for all Covered Injury and Covered Sickness combined is deleted.
  2. The benefit limit for one visit per day is deleted from the Physician's Visits while Confined benefit.
- E. All references to the "Health Wellness Benefit" and the "Health Wellness Promotion Benefit" are deleted. The following benefits are added to the "Inpatient Benefits" provision in the "Description of Benefits" section.
10. **Skilled Nursing Facility Benefit** – We will provide benefits for confinement in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for custodial care or residential care is not covered, except as rendered as part of Hospice Care. As used in this benefit Skilled Nursing Facility means a facility licensed, and operated as set forth in applicable state law, which:
    - a. mainly provides inpatient care and treatment for persons who are recovering from an illness or injury;
    - b. provides care supervised by a Physician;
    - c. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
    - d. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
    - e. is not a rest, educational, or custodial facility or similar place.
  11. **Bariatric Surgery** - We will pay the Usual and Reasonable covered medical expenses incurred for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health for the long term reversal of morbid obesity. We will pay these expenses on the same basis as for other medical and surgical procedures.

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

- F. The following benefit is added to the "Outpatient Benefits" provision in the "Description of Benefits" section.
11. **Rehabilitation Therapy and Habilitative Services** – We will pay benefits for Rehabilitation Therapy and Habilitative Services, when prescribed by a Physician. The benefits will be paid as shown in the Schedule of Benefits.
- G. The following benefits are added to the "Other Benefits" provision in the "Description of Benefits" section.
17. **Routine Eye Exams (Adult)** - We will pay the Usual and Reasonable medical expenses incurred for an eye examination as may be included in a physical examination.
  18. **Urgent Care Centers or Facilities** We will pay the Usual and Reasonable charge for services provided at an Urgent Care Center or Facility, as shown in the Schedule of Benefits. We will not pay for more than one visit per day.
  19. **Chiropractic Care Benefit**– We will pay benefits for chiropractic care as described in the Schedule of Benefits.
  20. **Pediatric Vision Care Benefit** – this benefit only applies to Insured Persons who are age 18 and under. We will provide benefits for:
    - a. one comprehensive vision examination by an ophthalmologist or optometrist in a 12-month period;
    - b. One pair of standard lenses, for glasses or contact lenses, in a 12-month period;one pair of standard frames in a 12-month period. "Standard frames" refers to frames that are not designer frames, such as Coach, Burberry, Prada or other designers.
  21. **Pediatric Dental Care Benefit** - This benefit only applies to Insured Persons who are age 18 and under. This benefit is subject to: (1) the Deductible shown on the Policy Schedule of Insurance; and (2) the



following Coinsurance Amounts:

| Type of Service   | Coinsurance Amount |
|---|--------------------|
| Diagnostic and Restorative  | 0%                 |
| Endodontic, Periodontal, Prosthodontic, Oral and Maxillofacial Surgical | 50%                |
| Orthodontic Treatment   | 50%                |
| For all other services and supplies                                     | 50%                |

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

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

Diagnostic Services

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

- a) *Clinical oral evaluations once every 6 months \**
  1. Comprehensive oral evaluation– complete evaluation which includes a comprehensive and thorough inspection of the oral cavity to include diagnosis, an oral cancer screening, charting of all abnormalities, and development of a complete treatment plan allowed once per year with subsequent service as periodic oral evaluation
  2. Periodic oral evaluation – subsequent thorough evaluation of an established patient\*
  3. Oral evaluation for patient under the age of 3 and counseling with primary caregiver\*
  4. Limited oral evaluations that are problem focused
  5. Detailed oral evaluations that are problem focused
- b) Diagnostic Imaging with interpretation
  1. A full mouth series can be provided every 3 years. The number of films/views expected is based on age with the maximum being 16 intraoral films/views.
  2. An extraoral panoramic film/view and bitewings may be substituted for the full mouth series with the same frequency limit.
  3. Additional films/views needed for diagnosing can be provided as needed.
  4. Bitewings, periapicals, panoramic and cephalometric radiographic images
  5. Intraoral and extraoral radiographic images
  6. Oral/facial photographic images
  7. Maxillofacial MRI, ultrasound
  8. Cone beam image capture
- c) Tests and Examinations

- d) Viral culture
- e) Collection and preparation of saliva sample for laboratory diagnostic testing
- f) Diagnostic casts – for diagnostic purposes only and not in conjunction with other services
- g) Oral pathology laboratory
  - 1. Accession/collection of tissue, examination – gross and microscopic, preparation and transmission of written report
  - 2. Accession/collection of exfoliative cytologic smears, microscopic examination, preparation and transmission of a written report
  - 3. Other oral pathology procedures, by report

#### Preventive Services

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

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

#### Restorative Services

- There are no frequency limits on replacing restorations (fillings) or crowns.
- Request for replacement due to failure after insertion may require documentation to demonstrate material failure as the cause.
- Reimbursement will include the restorative material and all associated materials necessary to provide the standard of care, polishing or restoration, and local anesthesia.
- The reimbursement for any restoration on a tooth shall be for the total number of surfaces to be restored on that date of service.
- Only one procedure code is reimbursable per tooth except when amalgam and composite restorations are placed on the same tooth.
- Reimbursement for occlusal restoration includes any extensions onto the occlusal one-third of buccal, facial, or lingual surface(s) of the tooth.
- Extension of interproximal restorations into self-cleansing areas will not be considered as additional surfaces. Extension of any restoration into less than 1/3 of an adjacent surface is not considered an additional surface and will not be reimbursable (or if paid will be recovered).

Restorative service to include:

- a) Restorations (fillings) – amalgam or resin based composite for anterior and posterior teeth. Service includes local anesthesia, pulp cap (direct or indirect) polishing and adjusting occlusion.
- b) Gold foil - Service includes local anesthesia, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program.
- c) Inlay/onlay restorations – metallic, service includes local anesthesia, cementation, polishing and adjusting occlusion but only covered if the place of service is a teaching institution or residency program
- d) Porcelain fused to metal, cast and ceramic crowns (single restoration) – to restore form and function.
  - 1. Service requires prior authorization and will not be considered for cosmetic reasons, for teeth where other restorative materials will be adequate to restore form and function or for teeth that are not in occlusion or function and have a poor long term prognosis
  - 2. Service includes local anesthesia, temporary crown placement, insertion with cementation, polishing and adjusting occlusion.
  - 3. Provisional crowns are not covered.
- e) Re-cement of inlay, onlay, custom fabricated/cast or prefabricated post and core and crown,
- f) Prefabricated stainless steel, stainless steel crown with resin window and resin crowns. Service includes local anesthesia, insertion with cementation and adjusting occlusion.

- g) Core buildup including pins
- h) Pin retention
- i) Indirectly fabricated (custom fabricated/cast) and prefabricated post and core
- j) Additional fabricated (custom fabricated/cast) and prefabricated post
- k) Post removal
- l) Temporary crown (fractured tooth)
- m) Additional procedures to construct new crown under existing partial denture
- n) Coping
- o) Crown repair
- p) Protective restoration/sedative filling

#### Endodontic Services

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

Endodontic service to include:

- a) Therapeutic pulpotomy for primary and permanent teeth
- b) Pulpal debridement for primary and permanent teeth
- c) Partial pulpotomy for apexogenesis
- d) Pulpal therapy for anterior and posterior primary teeth
- e) Endodontic therapy and retreatment
- f) Treatment for root canal obstruction, incomplete therapy and internal root repair of perforation
- g) Apexification: initial, interim and final visits
- h) Pulpal regeneration
- i) Apicoectomy/Periradicular Surgery
- j) Retrograde filling
- k) Root amputation
- l) Surgical procedure for isolation of tooth with rubber dam
- m) Hemisection
- n) Canal preparation and fitting of preformed dowel or post
- o) Post removal

#### Periodontal Services

Services require prior authorization with submission of diagnostic materials and documentation of need.

- a) Surgical services
  1. Gingivectomy and gingivoplasty
  2. Gingival flap including root planning
  3. Apically positioned flap
  4. Clinical crown lengthening
  5. Osseous surgery
  6. Bone replacement graft – first site and additional sites
  7. Biologic materials to aid soft and osseous tissue regeneration
  8. Guided tissue regeneration
  9. Surgical revision
  10. Pedicle and free soft tissue graft
  11. Subepithelial connective tissue graft
  12. Distal or proximal wedge
  13. Soft tissue allograft
  14. Combined connective tissue and double pedicle graft
- b) Non-Surgical Periodontal Service
  1. Provisional splinting – intracoronal and extracoronal – can be considered for treatment of dental trauma
  2. Periodontal root planning and scaling – with prior authorization, can be considered every 6 months for individuals with special healthcare needs
  3. Full mouth debridement to enable comprehensive evaluation

- 4. Localized delivery of antimicrobial agents
- c) Periodontal maintenance

Prosthodontic Services

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

Prosthodontic services to include:

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

5. Abutment teeth must be periodontally sound and have a good long term prognosis
  6. Repair and recementation)
- l) Pediatric partial denture – for select cases to maintain function and space for permanent anterior teeth with premature loss of primary anterior teeth, subject to prior authorization.

Oral and Maxillofacial Surgical Services

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

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

2. Skin and bone graft and synthetic graft
3. Collection and application of autologous blood concentrate
4. Osteoplasty and osteotomy
5. LeFort I, II, III with or without bone graft
6. Graft of the mandible or maxilla – autogenous or nonautogenous
7. Sinus augmentations
8. Repair of maxillofacial soft and hard tissue defects
9. Frenectomy and frenoplasty
10. Excision of hyperplastic tissue and pericoronal gingiva
11. Sialolithotomy, sialodochoplasty, excision of the salivary gland and closure of salivary fistula
12. Emergency tracheotomy
13. Coronoidectomy
14. Implant – mandibular augmentation purposes
15. Appliance removal – “by report” for provider that did not place appliance, splint or hardware

### Orthodontic Services

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

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

Orthodontic service to include:

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

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

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

Adjunctive General Services

- a) Palliative treatment for emergency treatment – per visit
- b) Anesthesia
  - 1. Local anesthesia NOT in conjunction with operative or surgical procedures.
  - 2. Regional block
  - 3. Trigeminal division block.
  - 4. Deep sedation/general anesthesia provided by a dentist regardless of where the dental services are provided for a medical condition covered by the policy or Certificate which requires hospitalization or general anesthesia. 2-hour maximum time
  - 5. Intravenous conscious sedation/analgesia – 2-hour maximum time
  - 6. Nitrous oxide/analgesia
  - 7. Non-intravenous conscious sedation – to include oral medications
- c) Behavior management – for additional time required to provide services to a child with special needs that requires more time than generally required to provide a dental service. Request must indicate specific medical diagnosis and clinical appearance.
  - One unit equals 15 minutes of additional time
  - Utilization thresholds are based on place of service as follows. Prior authorization is required when thresholds are exceeded.
    - Office or Clinic maximum – 2 units
    - Inpatient/Outpatient hospital – 4 units
    - Skilled Nursing/Long Term Care – 2 units
- d) Consultation by specialist or non-primary care provider
- e) Professional visits
  - House or facility visit – for a single visit to a facility regardless of the number of members seen on that day.
  - Hospital or ambulatory surgical center call
    - For cases that are treated in a facility.
    - For cases taken to the operating room – dental services are provided for patient with a medical condition covered by the policy/Certificate which requires this admission as in-patient or out-patient. Prior authorization is required.
    - General anesthesia and outpatient facility charges for dental services are covered
    - Dental services rendered in these settings by a dentist not on staff are considered separately
  - Office visit for observation – (during regular hours) no other service performed
- f) Drugs
  - Therapeutic parenteral drug
    - Single administration
    - Two or more administrations - not to be combined with single administration
  - Other drugs and/or medicaments – by report
- g) Application of desensitizing medicament – per visit
- h) Occlusal guard – for treatment of bruxism, clenching or grinding
- i) Athletic mouthguard covered once per year
- j) Occlusal adjustment
  - Limited – (per visit)
  - Complete (regardless of the number of visits), once in a lifetime
- k) Odontoplasty
- l) Internal bleaching

H. The “Mandated and Must Offer Benefits for New Jersey” provision in the “Description of Benefits” section is amended as follows:

The Treatment of Autism or Other Developmental Disabilities benefit is deleted and replaced with the following:

**Treatment of Non-pervasive Developmental Disabilities** – We will pay the Usual and Reasonable expenses incurred for:

1. The screening and diagnosis of non-pervasive developmental disabilities.
2. Medically Necessary physical therapy, occupational therapy and speech therapy services prescribed through a treatment plan for the treatment of non-pervasive developmental disability, subject to the limits shown in the schedule.
3. Expenses incurred by an Insured Person for services under item 2 above when obtained through the New Jersey Early Intervention System when participating in an individualized family service plan through a Family Cost Share. Coverage will be provided without consideration of whether the services are restorative or have a restorative effect. The benefits will be paid on the same basis as any other Covered Sickness.

The maximum benefit amount for an Insured Person is shown in the Schedule of Benefits.

The following definitions apply to this benefit:

**Non-pervasive Developmental Disability** as defined in the New Jersey Developmentally Disabled Rights Act, means a severe, chronic disability of a person which:

1. is attributable to a mental or physical impairment or combination of mental or physical impairments;
2. is manifested before age 22;
3. is likely to continue indefinitely;
4. results in substantial functional limitations in three or more of the following areas of major life activity, that is, self-care, receptive and expressive language, learning, mobility, self-direction and capacity for independent living or economic self-sufficiency; and
5. reflects the need for a combination and sequence of special inter-disciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated.

Non-pervasive Developmental Disability includes but is not limited to severe disabilities attributable to mental retardation, cerebral palsy, epilepsy, spina-bifida and other neurological impairments where the above criteria are met. Behavioral Interventions Based on ABA are interventions or strategies based upon learning theory that are intended to improve socially important behavior of an individual using instructional and environmental modifications that have been evaluated through scientific research using reliable and objective measurements, including the empirical identification of functional relations between behavior and environmental factors. Behavioral Intervention strategies based on ABA include, but are not limited to: (1) chaining; (2) functional analysis; (3) functional assessment; (4.) functional communication training; (5) modeling, including video modeling (also known as imitation training); (6) procedures designed to reduce challenging and dangerous behaviors (e.g., differential reinforcement, extinction, time out, and response cost); (7) prompting; and (8) reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization. Related Structured Behavioral Programs are services delivered by a qualified practitioner that are comprised of multiple intervention strategies (that is, behavioral intervention packages) based upon the principles of ABA. These packages may include but are not limited to: (1) activity schedules; (2) discrete trial instruction; (3) incidental teaching; (4) natural environment training; (5) picture exchange communication system; (6) pivotal response treatment; (7) script and script-fading procedures; and (8) self-management.

The **Biologically Based Mental Illness** benefit is deleted.

The **Alcoholism Treatment Benefit** is deleted.

- I. The “Exclusions and Limitations” Section is amended as follows:

The following exclusion is deleted:

- weak, strained or flat feet, corns, calluses or ingrown toenails.

It is replaced with the following:

weak, strained or flat feet, corns, calluses or ingrown toenails unless the treatment is a cutting operation that is performed in conjunction with the treatment of metabolic or peripheral vascular disease.

The following paragraph is added when the birth control exclusion is included in the Policy/Certificate:

NOTICE: Your institution of higher education has certified that your student health insurance coverage qualifies for an accommodation with respect to the federal requirement to cover all Food and Drug Administration-approved contraceptive services for women, as prescribed by a health care provider, without cost sharing. This means that your institution of higher education will not contract, arrange, pay, or refer for contraceptive coverage.

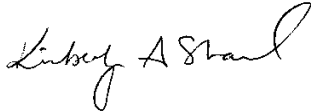


Instead, National Guardian Life Insurance Company will provide separate payments for contraceptive services that you use, without cost sharing and at no other cost, for so long as you are enrolled in your student health insurance coverage. Your institution of higher education will not administer or fund these payments. If you have any questions about this notice, contact National Guardian Life Insurance Company c/o Commercial Travelers Mutual Insurance company, 70 Genesee Street Utica, NY 13502.

This Rider takes effect with and expires on the same date as the Policy to which it is attached.

There are no other changes to the Policy or Certificate.

In witness whereof We have caused this Rider to be signed by Our President and Secretary.



Kimberly A. Shaul, Secretary



Mark L. Solverud, President

See Master Policy For Signature  
Policyholder Signature

Drew University –Graduate Plan  
Printed Name, Title

August 15, 2017  
Date

**SCHEDULE OF BENEFITS**  
**Gold Plan**

We offer a PPO Provider Network as healthcare delivery system for your health plan. You may utilize the services of Network and Non-Network Providers. The Schedule of Benefits included in this PPO Rider takes the place of the Schedule of Benefits provided in your Policy/Certificate of Coverage. Your Schedule of Benefits describes important things about your health insurance plan, like your benefit limits and your Network and Non-Network cost-sharing amounts for the Covered Services you will receive during the Policy Year (the 12-month period that begins on the effective date of your coverage). **Please read** your Policy/Certificate of Coverage, Schedule of Benefits and any Benefit Riders for complete coverage details, benefit limitations and exclusions.

**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).

**Preventive Services:**

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

Non-Network: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the actual charge/Usual and Reasonable charge.

**Deductible:**

|             |       |
|-------------|-------|
| Network     | \$300 |
| Non-Network | \$300 |

**Out-of-Pocket Expense Limit:**

|                       |                        |
|-----------------------|------------------------|
| Network Provider:     | \$6,350 per individual |
| Non-Network Provider: | No maximum             |

**Coinsurance Amount:**

|                       |  |
|-----------------------|--|
| Network Provider:     | 80% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.                     |
| Non-Network Provider: | 70% of Usual and Reasonable charge (U&R) for Covered Medical Expenses unless otherwise stated below. |

**Benefit Payment for Network Providers and Non-Network Providers**

The policy/Certificate provides benefits based on the type of health care provider selected. The policy/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.

**PREFERRED PROVIDER ORGANIZATION:**

To locate a Cigna Provider in Your area, consult Your Provider Directory, go to [www.cigna.com](http://www.cigna.com), or contact Consolidated Health Plans, toll-free at (877) 657-5030, or [www.chpstudent.com](http://www.chpstudent.com) for assistance.

**THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:**

1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.

| BENEFITS PER COVERED INJURY/SICKNESS   | NETWORK                                      | NON-NETWORK                                  |
|--|--|--|
| <b>Inpatient Benefits</b>  |  |  |
| Hospital Room & Board Expenses   | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Hospital Intensive Care Unit Expense - <i>in lieu of normal Hospital Room &amp; Board Expenses</i>   | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Preadmission Testing   | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Physician's Visits while Confined  | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Inpatient Surgery:   |  |  |
| Surgeon Services   | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Anesthetist  | 25% of benefits payable for Surgeon Services | 25% of benefits payable for Surgeon Services |
| Assistant Surgeon  | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Physical Therapy (inpatient)   | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Skilled Nursing Facility Benefit   | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Bariatric Surgery  | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| <b>Outpatient Benefits</b>   |  |  |
| Outpatient Surgery:  |  |  |
| Surgeon Services   | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |
| Anesthetist  | 25% of benefits payable for Surgeon Services | 25% of benefits payable for Surgeon Services |
| Assistant Surgeon  | The PPO Allowance stated above               | The Usual and Reasonable Charge stated above |

| BENEFITS PER COVERED INJURY/SICKNESS   | NETWORK   | NON-NETWORK  |
|--|---|--|
| 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 | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| Physical Therapy (Outpatient)  | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| Emergency Services Expenses  | The PPO Allowance for Covered Medical Expenses; Deductible waived if Student Health Center Referred                               | The Network PPO Allowance for Covered Medical Expenses; Deductible waived if Student Health Center Referred  |
| In Office Physician’s Visits   | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| Diagnostic X-ray Services, Includes MRI and tomography   | The PPO Allowance stated above; Deductible waived if Student Health Center Referred   | The Usual and Reasonable Charge stated above; Deductible waived if Student Health Center Referred  |
| Laboratory Procedures (Outpatient)   | The PPO Allowance stated above; Deductible waived if Student Health Center Referred   | The Usual and Reasonable Charge stated above; Deductible waived if Student Health Center Referred  |
| Prescription Drugs (Copay based on 30 day supply)  | 100% of PPO Allowance for Covered Medical Expenses after the following Copayments: \$15 Generic; \$30 Preferred Brand; \$50 Brand | 100% of PPO Allowance for Covered Medical Expenses after the following Copayments: \$15 Generic; \$30 Preferred Brand; \$50 Brand<br><i>(Claims will be paid on a reimbursement basis)</i> |
| Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery  | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| Hospice Care Coverage  | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy   | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| Habilitative services are covered to the extent that they are Medically Necessary  | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| <b>Other Benefits</b>  |   |  |
| Ambulance Service, Ground and/or Air Transportation  | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |
| Braces and Appliances including Prosthesis and Orthotics   | The PPO Allowance stated above  | The Usual and Reasonable Charge stated above   |

| <b>BENEFITS PER COVERED INJURY/SICKNESS</b>   | <b>NETWORK</b>   | <b>NON-NETWORK</b>   |
|---|--|--|
| Durable Medical Equipment   | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above                         |
| Maternity Benefit   | Same as any other Covered Sickness   | Same as any other Covered Sickness                                   |
| Routine Newborn Care  | Same as any other Covered Sickness   | Same as any other Covered Sickness                                   |
| Consultant Physician Services   | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above                         |
| Accidental Injury Dental Treatment for Insured Person's over age 18   | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above                         |
| Sickness Dental Expense for Insured Persons over age 18   | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above                         |
| Student Health Center/Infirmary Expense   | 100% of Usual and Reasonable Charge for Covered Medical Expenses; Deductible waived                            |  |
| Abortion Expense  | No Benefit   | No Benefit   |
| Bedside Visits (International Students and/or their Dependents Only)  | 100% of Usual and Reasonable Charge for Covered Medical Expenses, Subject to a \$5,000 Maximum per Policy Year |  |
| Medical Treatment Received in Home Country (International Students and/or their Dependents Only)                | 70% of Usual and Reasonable Charge for Covered Medical Expenses  |  |
| Medical Evacuation Expense  | 100% of Usual and Reasonable Charge for Covered Medical Expenses   |  |
| Repatriation Expense  | 100% of Usual and Reasonable Charge for Covered Medical Expenses   |  |
| Routine Eye Exams (Adult); Eye screenings provided as part of a routine physical exam                           | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above                         |
| Urgent Care Centers or Facilities   | The PPO Allowance stated above   | The Usual and Reasonable Charge state above                          |
| Chiropractic Care, Limited to 30 Visits per Policy Year   | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above                         |
| Pediatric Vision Care Benefit, Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames | 100% of PPO Allowance for Covered Medical Expenses for Preventive Services                                     | The Usual and Reasonable Charge stated above for Preventive Services |

| BENEFITS PER COVERED INJURY/SICKNESS   | NETWORK  | NON-NETWORK   |
|--|--|---|
| <p><b>Pediatric Dental Care Benefit</b><br/>Preventive Pediatric Dental Care, Limited to 1 dental exam every 6 months<br/><i>The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:</i></p> <p>Diagnostic and Restorative</p> <p>Endodontic, Periodontal, Prosthodontic Oral and Maxillofacial Surgical</p> <p>Orthodontic Treatment</p> <p>For all other service supplies</p> | <p>See Benefit for limitations, 100% of PPO Allowance Stated above for Preventive Services, No Deductible, Copayment, or Coinsurance will be applied to Preventive Care when services received in Network</p> <p>0%</p> <p>50%</p> <p>50%</p> <p>50%</p> | <p>See Benefit for limitations; The Usual and Reasonable Charge stated above for Preventive Services</p> <p>0%</p> <p>50%</p> <p>50%</p> <p>50%</p> |
| <b>Mandated Benefits</b>   |  |   |
| <p>The following benefits are mandated coverages in the State of New Jersey and will be included in all School plans issued under the policy. Unless specified otherwise, all such coverage will be subject to any Deductible, Copayment and Coinsurance conditions of the policy. Coverage is also subject to all other terms and conditions applicable to any other Covered Injury or Covered Sickness.</p>  |  |   |
| Non-pervasive Developmental Disability Benefit   | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above  |
| Infant Formulae Benefit  | Same as any other Covered Sickness   | Same as any other Covered Sickness  |
| Audiology and Speech Language Pathology Benefit  | Same as any other Covered Sickness   | Same as any other Covered Sickness  |
| Therapeutic Treatment of Inherited Metabolic Disease Benefit   | Same as any other Covered Sickness   | Same as any other Covered Sickness  |
| Treatment of Cancer; Bone Marrow Transplants Benefit   | Same as any other Covered Sickness   | Same as any other Covered Sickness  |
| Dental Treatment for the Severely Disabled or Children Benefit   | Same as any other Covered Sickness   | Same as any other Covered Sickness  |
| Hemophilia Treatment Expense Benefit   | Same as any other Covered Sickness   | Same as any other Covered Sickness  |
| Orthotic or Prosthetic Appliances Benefit  | Same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule   | Same rate as reimbursement for such appliances under the federal Medicare reimbursement schedule  |
| Screening for Newborn Hearing Loss Benefit   | Same as any other Covered Sickness (This benefit is not subject to a Deductible)   | Same as any other Covered Sickness (This benefit is not subject to a Deductible)  |
| Home Health Care Benefit, up to 60 visits per Policy Year  | The PPO Allowance stated above   | The Usual and Reasonable Charge stated above  |
| Treatment of Wilm's Tumor Benefit  | Same as any other Covered Sickness   | Same as any other Covered Sickness  |

| <b>BENEFITS PER COVERED INJURY/SICKNESS</b>   | <b>NETWORK</b>                              | <b>NON-NETWORK</b>                           |
|---|---|--|
| Mastectomy and Reconstructive Breast Surgery Benefit  | The PPO Allowance stated above              | The Usual and Reasonable Charge stated above |
| Treatment of Diabetes Benefit   | Same as any other Covered Sickness          | Same as any other Covered Sickness           |
| Lead Screening for Children   | Same as any other Covered Sickness          | Same as any other Covered Sickness           |
| Mammography Benefit   | Same as any other Covered Sickness          | Same as any other Covered Sickness           |
| Diagnosis and Treatment of Infertility  | Same as any other Covered Sickness          | Same as any other Covered Sickness           |
| Registered Nurse First Assistant  | Paid on the same basis as Assistant Surgeon | Paid on the same basis as Assistant Surgeon  |
| Hearing Aid Expense not to exceed \$1,000.00 per individual hearing aid for each hearing-impaired ear every two (2) years | Same as any other Covered Sickness          | Same as any other Covered Sickness           |
| Oral Anticancer Medication  | Same as any other Covered Sickness          | Same as any other Covered Sickness           |
| Sickle Cell Diagnosis and Treatment   | Same as any other Covered Sickness          | Same as any other Covered Sickness           |
| Prostate Screening Benefit  | Same as any other Covered Sickness          | Same as any other Covered Sickness           |



A Mutual Company Incorporated in 1909  
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### AMENDMENT TO DEFINITIONS

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

The definition of Accident is deleted in its entirety and replaced with the following:

**Accident** means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

The definition of Covered Injury is deleted in its entirety and replaced with the following:

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

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

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

Signed for National Guardian Life Insurance Company, at its Home Office in Madison, Wisconsin.

**Kimberly A. Shaul**  
Secretary

**Mark L. Solverud**  
President

NBH Amend Def

*Subject to Insurance Department Approval*



## CLAIM PROCEDURES

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

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

## VALUE ADDED SERVICES

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

### VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

[www.chpstudent.com](http://www.chpstudent.com)

### EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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