2013-2014

STUDENT INJURY AND SICKNESS INSURANCE PLAN

Designed Especially for Students of

GOUCHER college

Important: Please see the Notice on the first page of this plan material concerning student health insurance coverage.

This certificate is not a Medicare supplement certificate. It is not designed to fill the 'gaps' of Medicare. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from the Company.

UnitedHealthcare Insurance Company

Administered By:
UnitedHealthcare **Student**Resources
PO Box 809025
Dallas, TX 75380-9025

UnitedHealthcare®
A UnitedHealth Group Company

12-BR-MD 19-376-82

Notice Regarding Your Student Health Insurance Coverage

Your student health insurance coverage, offered by UnitedHealthcare Insurance Company, may not meet the minimum standards required by the health care reform law for restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions on annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012 and $500,000 for policy years beginning on or after September 23, 2012 but before January 1, 2014. Your student health insurance coverage puts a policy year limit of $500,000 that applies to the essential benefits provided in the Schedule of Benefits unless otherwise specified. If you have any questions or concerns about this notice, contact Customer Service at 1-800-505-4160. Be advised that you may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's employer plan or the parent's individual health insurance issuer for more information.

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Privacy Policy

We know that your privacy is important to you and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at 800-505-4160 or by visiting us at **www.firststudent.com.**

Eligibility

All Undergraduate students taking 12 or more credit hours (at least 7 credit hours for a student with a documented disability) are required to purchase this insurance Plan, unless proof of comparable coverage is furnished. All graduate students taking 9 or more credit hours (including On-Line Courses for Graduate Students) (at least 7 credit hours for a student with a documented disability) are eligible to enroll in this insurance Plan.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence and online courses do not fulfill the Eligibility requirements that the student must actively attend classes. 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.

Eligible students who do enroll may also insure their Dependents. Eligible Dependents are the student's spouse or Domestic Partner and dependent children including a natural child, stepchild, Adopted Child, grandchild, child placed with the Insured for legal adoption, child of a Domestic Partner, or a child for whom the Named Insured is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration and a child for whom the Named Insured is under a court order to provide coverage, under 26 years of age. .A dependent shall also mean a dependent of the Insured as the term is used in 26 U.S.C §§ 104, 105, 106, and any regulations adopted under those sections. See the Definitions section of the Certificate for the specific requirements needed to meet Domestic Partner eligibility.

Dependent Eligibility expires concurrently with that of the Insured student.

Effective and Termination Dates

The Master Policy on file at the school becomes effective at 12:01 a.m., August 21, 2013. The individual student's coverage becomes effective on the first day of the period for which premium is paid or the date the enrollment form and full premium are received by the Company (or its authorized representative), whichever is later. The Master Policy terminates at 11:59 p.m., August 20, 2014. Coverage terminates on that date or at the end of the period through which premium is paid, whichever is earlier. Dependent coverage will not be effective prior to that of the Insured student or extend beyond that of the Insured student.

Refunds of premiums are allowed only upon entry into the armed forces

The Policy is a Non-Renewable One Year Term Policy.

Extension of Benefits After Termination

The coverage provided under the Policy ceases on the Termination Date. However, if an Insured is Totally Disabled on the Termination Date from a covered Injury or Sickness for which benefits are payable before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the Insured remains Totally Disabled but not to exceed 12 months after the Termination Date. Proof of Total Disability may be required at any time.

If an Insured begins a course of Dental Treatment before the Termination Date and requires two or more visits on separate days to a dentist's office, Covered Medical Expenses for such course of treatment will continue to be paid but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit.

After this "Extension of Benefits" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

Pre-Admission Notification

UnitedHealthcare should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.
2. **NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS:** The patient, patient's representative, Physician or Hospital should telephone 1-877-295-0720 within two working days of the admission to provide notification of any admission due to Medical Emergency.

UnitedHealthcare is open for Pre-Admission Notification calls from 8:00 a.m. to 6:00 p.m. C.S.T., Monday through Friday. Calls may be left on the Customer Service Department's voice mail after hours by calling 1-877-295-0720.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the policy; however, pre-notification is not a guarantee that benefits will be paid.

Schedule of Medical Expense Benefits

Injury and Sickness

Maximum Benefit: $500,000 Paid As Specified Below (Per Insured Person) (Per Policy Year)

Deductible Preferred Provider: $150 (Per Insured Person) (Per Policy Year)

Deductible Out-of-Network Provider: $400 (Per Insured Person) (Per Policy Year)

Coinsurance Preferred Provider: 80% except as noted below
Coinsurance Out-of-Network: 60% except as noted below

Out-of-Pocket Maximum Preferred Provider: $2,500 (Per Insured Person, Per Policy Year)

Out-of-Pocket Maximum Out-of-Network: $5,000 (Per Insured Person, Per Policy Year)

The Preferred Provider for this plan is UnitedHealthcare Choice Plus.

If care is received from a Preferred Provider any Covered Medical Expenses will be paid at the Preferred Provider level of benefits. See the Preferred Provider Information section for out-of-network provider access and payment information in certain circumstances. If the Covered Medical Expense is incurred due to a Medical Emergency, benefits will be paid at the Preferred Provider level of benefits. In all other situations, reduced or lower benefits will be provided when an Out-of-Network provider is used.

The Policy provides benefits for the Covered Medical Expenses incurred by an Insured Person for loss due to a covered Injury or Sickness up to the Maximum Benefit of $500,000.

Out-of-Pocket Maximum: After the Out-of-Pocket Maximum has been satisfied, Covered Medical Expenses will be paid at 100% up to the policy Maximum Benefit subject to any benefit maximums that may apply. Separate Out-of-Pocket Maximums apply to Preferred Provider and Out-of-Network benefits. Copays and per service Deductibles and services that are not Covered Medical Expenses do not count toward meeting the Out-of-Pocket Maximum. Even when the Out-of-Pocket Maximum has been satisfied, the Insured Person will still be responsible for Copays and per service Deductibles.

Student Health Center Benefits: Deductibles and Copays will be waived and benefits will be paid at 100% for Expenses incurred when treatment is rendered at the Student Health Center, including the following services: Acupuncture and Prescription Drugs.

Benefits are subject to the policy Maximum Benefit unless otherwise specifically stated. Benefits will be paid up to the maximum benefit for each service as scheduled below. All benefit maximums are combined Preferred Provider and Out-of-Network unless otherwise specifically stated. Covered Medical Expenses include:

PA = Preferred Allowance	U&C = Usual & Customary Charges	
INPATIENT	**Preferred Providers**	**Out-of-Network Providers**
Room and Board Expense, for the state of Maryland facilities, rate approved by Health Services Cost Review Commission (HSCRC) and for all other areas, daily semi-private room rate when confined as an Inpatient; and general nursing care provided by the Hospital.	80% of PA	60% of U&C
Intensive Care	80% of PA	60% of U&C
Hospital Miscellaneous Expenses, such as the cost of the operating room, laboratory tests including blood products, both derivatives and components, x-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. In computing the number of days payable under this benefit, the date of admission will be counted, but not the date of discharge.	80% of PA	60% of U&C
Routine Newborn Care, *See Benefits for Maternity Expenses*	Paid as any other Sickness	
Physiotherapy	80% of PA	60% of U&C
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with Inpatient surgery.	80% of PA	60% of U&C
Registered Nurse's Services, private duty nursing care.	80% of PA	60% of U&C
Physician's Visits, non-surgical services when confined as an Inpatient. Benefits do not apply when related to surgery.	80% of PA	60% of U&C
Pre-Admission Testing, payable within 3 working days prior to admission.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Surgeon's Fees, if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 50% of all subsequent procedures.	80% of PA	60% of U&C
Day Surgery Miscellaneous, related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory tests and x-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.	80% of PA	60% of U&C
Assistant Surgeon	80% of PA	60% of U&C
Anesthetist, professional services administered in connection with outpatient surgery.	80% of PA	60% of U&C
Physician's Visits, benefits for Physician's Visits do not apply when related to surgery or Physiotherapy.	100% of PA $25 Copay per visit	60% of U&C
Physiotherapy, Physiotherapy includes but is not limited to the following: 1) physical therapy; 2) occupational therapy; 3) cardiac rehabilitation therapy; 4) manipulative treatment; and 5) speech therapy, unless excluded in the policy. *See also Benefits for Habilitative Services for Children.*	80% of PA	60% of U&C
Medical Emergency Expenses, only in connection with a Medical Emergency for Emergency Services and the facility charge for use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of Injury or first onset of Sickness. See Out-of-Network Emergency Services, page 11.	100% of PA / $150 Copay per visit	100% of U&C / $150 Deductible per visit
Diagnostic X-ray Services	80% of PA	60% of U&C
Radiation Therapy	80% of PA	60% of U&C
Chemotherapy	80% of PA	60% of U&C
Laboratory Services, including blood products both derivatives and components.	80% of PA	60% of U&C

OUTPATIENT	Preferred Providers	Out-of-Network Providers
Tests & Procedures, diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, x-rays and lab procedures. The following therapies will be paid under this benefit: inhalation therapy, infusion therapy, pulmonary therapy and respiratory therapy.	80% of PA	60% of U&C
Injections, when administered in the Physician's office and charged on the Physician's statement.	80% of PA	60% of U&C
Prescription Drugs, When a Prescription Drug is classified as a Maintenance Medication according to Maryland law and as written by the Physician: Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug; and thereafter, up to a consecutive 90 day supply of a Prescription Drug subject to a Copay per prescription at 2.5 times the Copay for a 31 day supply. The applicable Copay and/or Coinsurance will never be greater than the cost of the prescription drug.	Prescription Drugs from a Retail or Mail-Order UnitedHealthcare Pharmacy (UHCP), $15 Copay per prescription for Tier 1 $35 Copay per prescription for Tier 2 $60 Copay per prescription for Tier 3 up to a 31-day supply per prescription	$15 Deductible per prescription for generic drugs $35 Deductible per prescription for brand name up to a 31-day supply per prescription.
OTHER		
Ambulance Services	100% of PA	100% of U&C
Durable Medical Equipment, a written prescription must accompany the claim when submitted. Benefits are limited to the initial purchase or one replacement purchase per Policy Year. *See also Benefits for Prosthetic Devices* *($1,000 maximum Per Policy Year) (Durable Medical Equipment benefits payable under the $1,000 maximum are not included in the $500,000 Maximum Benefit.)*	80% of PA	80% of U&C
Consultant Physician Fees, when requested and approved by attending Physician.	100% of PA $25 Copay per visit	60% of U&C
Dental Treatment, made necessary by Injury to Sound, Natural Teeth only. *($1,000 maximum Per Policy Year)* (Benefits are not subject to the $500,000 Maximum Benefit.)	80% of U&C	80% of U&C

OTHER	Preferred Providers	Out-of-Network Providers
Home Health Care	See Benefits for Home Health Care	
Mental Illness Treatment, *See Benefits for Mental Illness and Substance Use Disorder.*	Paid as any other Sickness	
Substance Use Disorder Treatment, *See Benefits for Mental Illness and Substance Use Disorder.*	Paid as any other Sickness	
Maternity, *See Benefits for Maternity Expenses.*	Paid as any other Sickness	
Complications of Pregnancy	Paid as any other Sickness	
Elective Abortion, *($1,000 maximum Per Policy Year) (Elective Abortion benefits are not subject to the $500,000 Maximum Benefit.)*	80% of PA	60% of U&C
Preventive Care Services, medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease, have been proven to have a beneficial effect on health outcomes and are limited to the following as required under applicable law: 1) Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendation of the United States Preventive Service Task Force regarding breast cancer screening, mammography and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009; 2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; 3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and 4) with respect to women, such additional preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration. No Deductible or Copays will be applied to Preventive Care Services.	100% of PA	80% of U&C
Reconstructive Breast Surgery Following Mastectomy, in connection with a covered Mastectomy.	See Benefits for Reconstructive Surgery Following a Mastectomy	
Diabetes Services	See Benefits for Treatment of Diabetes	
Urgent Care Center, facility or clinic fee billed by the Urgent Care Center. All other services rendered during the visit will be paid as specified in the Schedule of Benefits.	100% of PA / $50 Copay per visit	80% of U&C/ $50 Deductible per visit

UnitedHealthcare Pharmacy Benefits

Benefits are available for outpatient Prescription Drugs on our Prescription Drug List (PDL) when dispensed by a UnitedHealthcare Pharmacy. Benefits are subject to supply limits and Copayments that vary depending on which tier of the PDL the outpatient drug is listed. There are certain Prescription Drugs that require your Physician to notify us to verify their use is covered within your benefit.

You are responsible for paying the applicable Copayments. Your Copayment is determined by the tier to which the Prescription Drug is assigned on the PDL. Tier status may change periodically and without prior notice to you. Please access www.firststudent.com or call 1-855-828-7716 for the most up-to-date tier status.

Prescription Drugs from a Retail or Mail-Order Pharmacy

$15 Copay per prescription order or refill for a Tier 1 Prescription Drug up to a 31 day supply

$35 Copay per prescription order or refill for a Tier 2 Prescription Drug up to a 31 day supply

$60 Copay per prescription order or refill for a Tier 3 Prescription Drug up to a 31 day supply

When a Prescription Drug is classified as a Maintenance Medication according to Maryland law and as written by the Physician:

- Up to a consecutive 31-day supply for a new prescription or a change in prescription of a Prescription Drug; and
- Thereafter, up to a consecutive 90-day supply of a Prescription Drug subject to a Copay per prescription at 2.5 times the Copay for a 31 day supply.

Copayment and/or Coinsurance Amount

For Prescription Drug Products at a retail Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The Network Pharmacy's Usual and Customary Fee for the Prescription Drug Product.

For Prescription Drug Products from a mail order Network Pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Copayment and/or Coinsurance; or
- The Prescription Drug Cost for that Prescription Drug Product.

Mandated Prescription Drug Benefits

For coverage details of Prescription Contraceptives and Nicotine Replacement Therapy Drugs, please see the Benefits for Prescription Contraceptives and Benefits for Nicotine Replacement Drugs in the Mandated Benefits section of this certificate.

Please present your ID card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for the Out-of-Network Deductible or Coinsurance for the prescription.

If you do not present your card, the pharmacy may require you to pay for the prescription drug product at the time it is dispensed. In that case you should submit a reimbursement form for prescriptions filled at a network pharmacy along with the paid receipt in order to be reimbursed. To obtain reimbursement forms, or for information about mail-order prescriptions or network pharmacies, please visit www.firststudent.com and log in to your online account or call 1-855-828-7716.

Additional Exclusions

In addition to the policy Exclusions and Limitations, the following Exclusions apply to Network Pharmacy Benefits:

1. Coverage for Prescription Drug Products for the amount dispensed (days' supply or quantity limit) which exceeds the supply limit.

2. Experimental or Investigational Services or Unproven Services and medications; medications used for experimental indications and/or dosage regimens determined by the Company to be experimental, investigational or unproven, except as specifically provided in the Benefits for Clinical Trial Costs.
3. Compounded drugs that do not contain at least one ingredient that has been approved by the U.S. Food and Drug Administration and requires a Prescription Order or Refill. Compounded drugs that are available as a similar commercially available Prescription Drug Product. Compounded drugs that contain at least one ingredient that requires a Prescription Order or Refill are assigned to Tier-3.
4. Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed, unless the Company has designated the over-the-counter medication as eligible for coverage as if it were a Prescription Drug Product and it is obtained with a Prescription Order or Refill from a Physician. Prescription Drug Products that are available in over-the-counter form or comprised of components that are available in over-the-counter form or equivalent. Certain Prescription Drug Products that the Company has determined are Therapeutically Equivalent to an over-the-counter drug. Such determinations may be made up to six times during a calendar year, and the Company may decide at any time to reinstate Benefits for a Prescription Drug Product that was previously excluded under this provision. Please access www.firststudent.com through the Internet or call Customer Service at the telephone number on your ID card for information on which over-the-counter drugs are excluded.

   Note: Notwithstanding this exclusion, we will provide immediate coverage for excluded Prescription Drug Products described above if, in the judgment of the authorized Prescriber; a) The over–the-counter drug is not equivalent to the Prescription Drug Product on the Prescription Drug List; or b) An equivalent over-the-counter drug: i) has been ineffective in treating the Insured's disease or condition; or ii) has caused or is likely to cause an adverse reaction or other harm to the Insured,
5. Any product for which the primary use is a source of nutrition, nutritional supplements, or dietary management of disease, even when used for the treatment of Sickness or Injury, except as required by state mandate.

Definitions

Network Pharmacy means a pharmacy that has:

- Entered into an agreement with the Company or an organization contracting on our behalf to provide Prescription Drug Products to Insured Persons.
- Agreed to accept specified reimbursement rates for dispensing Prescription Drug Products.
- Been designated by the Company as a Network Pharmacy.

Prescription Drug List means a list that categorizes into tiers medications, products or devices that have been approved by the U.S. Food and Drug Administration. This list is subject to the Company's periodic review and modification (generally quarterly, but no more than six times per calendar year). The Insured may determine to which tier a particular Prescription Drug Product has been assigned through the Internet at www.firststudent.com or call Customer Service at 1-855-828-7716.

Prescription Drug or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

Out-of-Network Prescription Drug Benefits

Benefits are available at an out-of-network pharmacy for Prescription Drugs as specified in the Schedule of Benefits subject to all terms of the policy.

Deductible and/or Coinsurance Amount

For Prescription Drugs at an out-of-network pharmacy, Insured Persons are responsible for paying the lower of:

- The applicable Deductible and/or coinsurance; or
- The Prescription Drug Cost for that Prescription Drug.

When prescriptions are filled at pharmacies outside the network, the pharmacy may require you to pay for the prescriptions out-of-pocket. You should submit the receipts for reimbursement to UnitedHealthcare **Student**Resources, P.O. Box 809025, Dallas, TX 75380-9025. See the Schedule of Benefits for the benefits payable at out-of-network pharmacies.

Preferred Provider Information

"Preferred Providers" are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices. Preferred Providers in the local school area are: Hospitals and Physicians of UnitedHealthcare Choice Plus.

The availability of specific providers is subject to change without notice. Insured's should always confirm that a Preferred Provider is participating at the time services are required by calling the Company at 1-800-505-4160 and/or by asking the provider when making an appointment for services.

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

"Out-of-Network" providers have not agreed to any prearranged fee schedules. Insured's may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are the Insured's responsibility.

Regardless of the provider, each Insured is responsible for the payment of their Deductible. The Company will pay according to the benefit limits in the Schedule of Benefits.

Inpatient Expenses

PREFERRED PROVIDERS - Eligible Inpatient expenses at a Preferred Provider will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. Preferred Hospitals include UnitedHealthcare Choice Plus United Behavioral Health (UBH) facilities. Call (800) 505-4160 for information about Preferred Hospitals.

OUT-OF-NETWORK PROVIDERS - If Inpatient care is not provided at a Preferred Provider, eligible Inpatient expenses will be paid according to the benefit limits in the Schedule of Benefits.

Outpatient Hospital Expenses

Preferred Providers may discount bills for outpatient Hospital expenses. Benefits are paid according to the Schedule of Benefits. Insureds are responsible for any amounts that exceed the benefits shown in the Schedule, up to the Preferred Allowance.

Professional & Other Expenses

Benefits for Covered Medical Expenses provided by UnitedHealthcare Choice Plus will be paid at the Coinsurance percentages specified in the Schedule of Benefits, up to any limits specified in the Schedule of Benefits. All other providers will be paid according to the benefit limits in the Schedule of Benefits.

Out-of-Network Emergency Services

When Emergency Services are provided by an Out-of-Network Provider for a Medical Emergency, benefits will be subject to the same Copay or Coinsurance amounts that are applicable to Emergency Services provided by a Preferred Provider. Benefits for Emergency Services received from an Out-of-Network Provider will be paid at the greater of the following, excluding any Copays or Coinsurance that would have been imposed if the service had been received from a Preferred Provider: 1) the benefits specified in the Schedule of Benefits; 2) the Preferred Allowance negotiated with Preferred Providers (if there is more than one amount negotiated with Preferred Providers, the amount shall be the median of these negotiated amounts); or 3) the amount payable calculated using the Company's Usual and Customary Charges; or 4) the amount that would be paid under Medicare (part A or part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Service. Any other provisions of the policy that apply to cost-sharing for services received from an Out of Network Provider, such as the policy Deductible or Out of Pocket Maximum, will continue to apply to Emergency Services received from an Out of Network Provider.

Referral to Out-of-Network Specialist Physician and Non-Physician Specialist in Certain Circumstances.

Referrals are not required to see Out-of-Network providers; however in certain circumstances a referral may be requested. An Insured Person may request a referral to a specialist Physician or a non-Physician specialist who is not part of the Preferred Provider network if:

1. the Company does not have in its provider panel a specialist Physician or a non-Physician specialist with the professional training and expertise to treat or provide health care services for the Sickness or Injury; or
2. the Company cannot provide reasonable access to a specialist Physician or a non-Physician specialist with the professional training and expertise to treat or provide health care services for the Sickness or Injury without unreasonable delay or travel.

Benefits in these two situations will be paid at the level of benefits shown as Preferred Provider benefits.

Payment to Out of Network On-Call Physicians or Hospital –Based Physicians

If an Out-of-Network on-call Physician or Hospital-based Physician has obtained and accepted an assignment of benefits from an Insured and notified the Company of the assignment in the manner prescribed by the Commissioner of Insurance, the on-call Physician or Hospital-based Physician may not: 1) collect from the Insured any money owed to the on-call Physician or Hospital-based Physician by the Company for covered services rendered to the Insured by the on-call Physician or Hospital-based Physician; or 2) maintain any action against the Insured to collect or attempt to collect any money owed by the Company for covered services rendered to the Insured by the on-call Physician or Hospital-based Physician. The Insured shall only be liable to the on-call Physician or Hospital-based Physician for any Deductible, Copayment, or Coinsurance amount owed by the Insured for covered services rendered to the Insured by the on-call Physician or Hospital-based Physician and payment or charges for services that are not covered services under the policy. If Medicare is the primary insurer and the Company is the secondary insurer, the on-call Physician or Hospital-based Physician may collect from the Insured any amount up to the Medicare approved or limiting amount, as specified under the federal Social Security Act, that is not owed to the on-call Physician or Hospital-based Physician by Medicare or the Company after coordination of benefits has been completed.

The Company will pay the on-call Physician or Hospital-based Physician for covered services rendered to an Insured when an assignment of benefits has been obtained and accepted and the Company has been notified as required: 1) within 30 days after receipt of a claim; and 2) in accordance with the reimbursement rates as required by Maryland Insurance Law. The Company may seek reimbursement from an Insured for any payment for a claim or portion of a claim submitted by an on-call Physician or Hospital-based Physician and paid by the Company that the Company determines is the responsibility of the Insured based on the policy provisions.

Payment to Out of Network Physicians Not On-Call or Hospital-Based

The Company will not: 1) prohibit the assignment of benefits to a Physician by an Insured; or 2) refuse to directly reimburse an Out of Network Physician under an assignment of benefits.

The Company may refuse to directly reimburse an Out of Network provider under an assignment of benefits if: 1) the Company receives notice of the assignment of benefits after the time the Company has paid the benefits to the Insured; 2) the Company, due to inadvertent administrative errors, has previously paid the Insured; 3) the Insured withdraws the assignment of benefits before the Company has paid the benefits to the Out of Network provider; or 4) the Insured paid the Out of Network provider the full amount due at the time of service.

Maternity Testing

The following maternity tests and screening exams will be considered for payment according to the policy benefits if all other policy provisions have been met.

Initial screening at first visit:

- Pregnancy test: urine human chorionic gonatropin (HCG)
- Asymptomatic bacteriuria: urine culture
- Blood type and Rh antibody
- Rubella
- Pregnancy-associated plasma protein-A (PAPPA) **(first trimester only)**
- Free beta human chorionic gonadotrophin (hCG) **(first trimester only)**
- Hepatitis B: HBsAg
- Pap smear
- Gonorrhea: Gc culture
- Chlamydia: chlamydia culture
- Syphilis: RPR
- HIV: HIV-ab
- Coombs test

Each visit: Urine analysis

Once every trimester: Hematocrit and Hemoglobin

Once during first trimester: Ultrasound

Once during second trimester:

- Ultrasound (anatomy scan)
- Triple Alpha-fetoprotein (AFP), Estriol, hCG or Quad screen test Alpha-fetoprotein (AFP), Estriol, hCG, inhibin-a

Once during second trimester if age 35 or over: Amniocentesis or Chorionic villus sampling (CVS)

Once during second or third trimester: 50g Glucola (blood glucose 1 hour postprandial)

Once during third trimester: Group B Strep Culture

Pre-natal vitamins are not covered. For additional information regarding Maternity Testing, please call the Company at 1-800-505-4160.

Coordination of Benefits Provision

Definitions

(1) Allowable Expenses: Any health care expense, including coinsurance, or copayments and without reduction for any applicable Deductible that is covered in full or in part by any of the Plans covering the Insured Person. If a Plan is advised by an Insured Person that all Plans covering the Insured Person are high-deductible health plans and the Insured Person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in s 223(c)(2)(C) of the Internal Revenue Code of 1986. If a Plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an allowable expense. Expenses that are not allowable include all of the following.

(a) The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the Plans provides coverage for private hospital rooms.

(b) For Plans that compute benefit payments on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit.

(c) For Plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees.

(d) If one Plan calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement or other similar reimbursement methodology and another Plan calculates its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the Secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Plan's payment arrangement and if the provider's contract permits, that negotiated fee or payment shall be the allowable expense used by the Secondary Plan to determine its benefits.

The amount of any benefit reduction by the Primary Plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, precertification of admission, and preferred provider arrangements.

(2) Plan: A form of coverage with which coordination is allowed.

Plan includes all of the following:

(a) Group insurance contracts and subscriber contracts.

(b) Uninsured arrangements of group or group-type coverage.

(c) Group coverage through closed panel plans.

(d) Group-type contracts, including blanket contracts.

(e) The medical care components of long-term care contracts, such as skilled nursing care.

(f) Medicare or other governmental benefits, as permitted by law, except for Medicare supplement coverage. That part of the definition of plan may be limited to the hospital, medical, and surgical benefits of the governmental program.

Plan does not include any of the following:

(a) Hospital indemnity coverage benefits or other fixed indemnity coverage.

(b) Accident only coverage.

(c) Limited benefit health coverage as defined by state law.

(d) Specified disease or specified accident coverage.

(e) School accident-type coverages that cover students for accidents only, including athletic injuries, either on a twenty four hour basis or on a "to and from school" basis;

(f) Benefits provided in long term care insurance policies for non-medical services, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care, and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.

(g) Medicare supplement policies.

(h) State Plans under Medicaid.

(i) A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan.

(j) An Individual Health Insurance Contract.

(3) Primary Plan: A Plan whose benefits for a person's health care coverage must be determined without taking the existence of any other Plan into consideration. A Plan is a primary plan if: 1) the Plan either has no order of benefit determination rules or its rules differ from those outlined in this Coordination of Benefits Provision; or 2) all Plans that cover the Insured Person use the order of benefit determination rules and under those rules the Plan determines its benefits first.

(4) Secondary Plan: A Plan that is not the Primary Plan.

(5) We, Us or Our: The Company named in the policy to which this endorsement is attached.

Rules for Coordination of Benefits - When an Insured Person is covered by two or more Plans, the rules for determining the order of benefit payments are outlined below.

The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

If an Insured is covered by more than one Secondary Plan, the Order of Benefit Determination rules in this provision shall decide the order in which the Secondary Plan's benefits are determined in relation to each other. Each Secondary Plan shall take into consideration the benefits of the Primary Plan or Plans and the benefits of any other Plans, which has its benefits determined before those of that Secondary Plan.

A Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying Plan is primary. This does not apply to coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out of network benefits.

If the Primary Plan is a closed panel plan and the Secondary Plan is not a closed panel plan, the Secondary Plan shall pay or provide benefits as if it were the Primary Plan when an Insured Person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

Order of Benefit Determination - Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber are determined before those of the Plan which covers the person as a Dependent. If the person is a Medicare beneficiary, and, as a result of the provisions of Title XVII of the Social Security Act and implementing regulations, Medicare is both (i) secondary to the plan covering the person as a dependent; and (ii) primary to the plan covering the person as other than a dependent, then the order of benefit is reversed. The plan covering the person as an employee, member, subscriber, policyholder or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

(2) Dependent Child/Parents Married or Living Together. When this Plan and another Plan cover the same child as a Dependent of different persons, called "parents" who are married or are living together whether or not they have ever been married:

(a) the benefits of the Plan of the parent whose birthday falls earlier in a year exclusive of year of birth are determined before those of the Plan of the parent whose birthday falls later in that year.

(b) However, if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

(3) Dependent Child/Parents Divorced, Separated or Not Living Together. If two or more Plans cover a person as a Dependent child of parents who are divorced or separated or are not living together, whether or not they have ever been married, benefits for the child are determined in this order:

If the specific terms of a court decree state that one of the parents is responsible for the health care services or expenses of the child and that Plan has actual knowledge of those terms, that Plan is Primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's Plan is Primary. This item shall not apply with respect to any Plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

If a court decree states that both parents are responsible for the child's health care expenses or coverage, the order of benefit shall be determined in accordance with part (2).

If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the child, the order of benefits shall be determined in accordance with the rules in part (2).

If there is no court decree allocating responsibility for the child's health care expenses or coverage, the order of benefits are as follows:

(a) First, the Plan of the parent with custody of the child.

(b) Then Plan of the spouse of the parent with the custody of the child.

(c) The Plan of the parent not having custody of the child.

(d) Finally, the Plan of the spouse of the parent not having custody of the child.

(4) Dependent Child/Non-Parental Coverage. If a Dependent child is covered under more than one Plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, as if those individuals were parents of the child.

(5) Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(6) COBRA or State Continuation Coverage. If a person whose coverage is provided under COBRA or under a right of continuation pursuant to federal or state law also is covered under another Plan, the following shall be the order of benefit determination:

(a) First, the benefits of a Plan covering the person as an employee, member or subscriber or as that person's Dependent.

(b) Second, the benefits under the COBRA or continuation coverage.

(c) If the other Plan does not have the rule described here and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

(7) Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that person for the shorter time.

If none of the provisions stated above determine the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on Benefits - When Our Plan is secondary, We may reduce Our benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to the Allowable Expense under its Plan that is unpaid by the Primary Plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the Secondary Plan shall credit to its Plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right to Recovery and Release of Necessary Information - For the purpose of determining applicability of and implementing the terms of this Provision, We may, without further consent or notice, release to or obtain from any other insurance company or organization any information, with respect to any person, necessary for such purposes. Any person claiming benefits under Our coverage shall give Us the information We need to implement this Provision. We will give notice of this exchange of claim and benefit information to the Insured Person when any claim is filed.

Facility of Payment and Recovery - Whenever payments which should have been made under our Coverage have been made under any other Plans, We shall have the right to pay over to any organizations that made such other payments, any amounts that are needed in order to satisfy the intent of this Provision. Any amounts so paid will be deemed to be benefits paid under Our coverage. To the extent of such payments, We will be fully discharged from Our liability.

Whenever We have made payments with respect to Allowable Expenses in total amount at any time, which are more than the maximum amount of payment needed at that time to satisfy the intent of this Provision, We may recover such excess payments. Such excess payments may be received from among one or more of the following, as We determine: any persons to or for or with respect to whom such payments were made, any other insurers, service plans or any other organizations.

Accidental Death and Dismemberment Benefits

Loss of Life, Limb or Sight

If such Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Insured Person or beneficiary may request the Company to pay the applicable amount below in addition to payment under the Medical Expense Benefits.

For Loss Of:

Life	$5,000
Two or More Members	$5,000
One Member	$2,500
Thumb or Index Finger	$1,250

Member means hand, arm, foot, leg, or eye. Loss shall mean with regard to hands or arms and feet or legs, dismemberment by severance at or above the wrist or ankle joint; with regard to eyes, entire and irrecoverable loss of sight. Only one specific loss (the greater) resulting from any one Injury will be paid.

Extension of Benefits after Termination: The coverage provided under this benefit ceases on the Termination Date. However, if the loss results from an Injury that occurred while the Insured was covered under this policy, benefits will be paid for such loss provided the loss occurs within 90 days after the date of such Injury.

Mandated Benefits

Benefits for Home Health Care

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for home health care services provided the: 1) Hospital or skilled nursing home confinement would otherwise have been required if home health care was not provided; and 2) the plan of treatment covering the home health care service is established and approved in writing by the Physician. Home health care must be provided by: 1) a person licensed under the Health Occupations Article or a home health aide; 2) a Hospital possessing a valid operating certificate, and certified to provide home health services; or, 3) a public or private health service or agency which is licensed as a home health agency pursuant to Title 19; Subtitle 4 of the Health General Article. Each visit up to 4 hours by a member of a home care team is considered as one home care visit. Benefits will be limited to a maximum of 40 visits per policy year.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Second Opinion Due to Hospital Utilization Review

Benefits will be paid for an objective second opinion given to the Insured Person when required due to a Hospital's utilization review program.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Maternity Expenses

Benefits will be paid for normal pregnancy and normal childbirth to the same extent as for any other Sickness subject to the following:

Benefits will be paid for a mother and newborn child for a minimum of:

1) 48 hours of inpatient hospitalization care after an uncomplicated vaginal delivery; and
2) 96 hours of inpatient hospitalization care after an uncomplicated cesarean section.

When the mother remains hospitalized for medical reasons beyond the minimum time specified above, newborn care will be provided for an additional 4 days of Hospital confinement.

If prescribed by the Physician, one Home Visit will be provided for a mother and her newborn child who remain in the Hospital for the above referenced lengths of time.

If the decision is made between the mother and the Physician for a shorter Hospital stay, then benefits will be provided for one Home Visit scheduled to occur within 24 hours after the Hospital discharge and one additional Home Visit if prescribed by the Physician.

"Home visit" shall:

1) be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;
2) be provided by a Registered Nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and
3) include any services required by the Physician.

With regard to this section only, Home Visits are not subject to any Copayment, Coinsurance or Deductible. Benefits will be provided even if the services do not occur within the time specified.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for In-Vitro Fertilization

Benefits will be paid for all outpatient expenses arising from in vitro fertilization to the same extent as benefits provided for other pregnancy related procedures.

Benefits shall apply if:

1) The patient is the Named Insured or a covered Dependent spouse of the Named Insured;
2) The Insured's oocytes are fertilized with the Insured's spouse's sperm;
3) The Insured and the Insured's spouse have a history of infertility of at least 2 years duration; or
4) The infertility is associated with any of the following medical conditions:
   a. endometriosis;
   b. exposure in utero to diethylstilbestrol, commonly known as DES;
   c. blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
   d. abnormal male factors, including oligospermia, contributing to the infertility;
5) The Insured has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the policy.
6) The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or to the American Fertility Society minimal standards for programs of in vitro fertilization.

This benefit will be limited to three (3) in vitro fertilization attempts per live birth, not to exceed a maximum lifetime benefit of $100,000.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Mammography

Benefits will be paid for breast cancer screening under the Preventive Care Services benefit or under this benefit, whichever is greater.

Breast cancer screenings covered by the Preventive Care Services benefit shall be payable as specified in the Preventive Care Services benefit in the Schedule of Benefits.

Breast cancer screenings payable under this benefit will be paid for that portion of charges which is not in excess of Usual and Customary Charges for any other breast cancer screening required in accordance with the latest screening guidelines issued by the American Cancer Society. Benefits shall not be subject to the Deductible or benefit limitations for specific types of services, but are subject to all Copayment, Coinsurance, or any other provisions of the policy. Benefits shall be subject to the overall policy maximum benefit. Such screening must be provided in facilities accredited by the American College of Radiology or certified or licensed under a program established by the state of Maryland

Benefits for Reconstructive Breast Surgery Following a Mastectomy

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for Reconstructive Breast Surgery and prosthesis for an Insured who has not had reconstruction surgery following a Mastectomy. Benefits shall include: 1) reconstruction of the breast on which the Mastectomy has been performed; 2) all stages of surgery and reconstruction of the nondiseased breast to establish symmetry; and 3) prosthesis and physical complications from all stages of the Mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Insured.

"Mastectomy" means the surgical removal of all or part of a breast.

"Reconstructive breast surgery" means surgery performed as a result of a Mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Hospitalization and Home Visits Following Mastectomy or Home Visits Following Testectomy/Orchiectomy

Benefits will be paid for the cost of inpatient hospitalization services for an Insured Person for a minimum of 48 hours following a Mastectomy. A home visit for an Insured Person remaining in the Hospital for at least the minimum of 48 hour will be paid if prescribed by the attending Physician. An Insured may request a shorter length of stay than stated above if the Insured decides, in consultation with the attending Physician, that less time is needed for recovery.

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges [or Preferred Allowance] for one home visit scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility for an Insured Person who receives less than 48 hours of inpatient hospitalization following a Mastectomy or a testectomy/orchiectomy or if the procedure is done on an outpatient basis. The Insured Person may receive an additional home visit if prescribed by their Physician.

"Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Chlamydia and Human Papillomavirus Screening Tests

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for the following screening tests for Insured Persons:

1) One annual routine Chlamydia Screening Test for:
   a) Women who are under the age of 20 years if they are sexually active, and at least 20 years old if they have multiple risk factors; and
   b) Men who have Multiple Risk Factors

"Chlamydia screening test" means any laboratory test that:

a) Specifically detects for infection by one or more agents of chlamydia trachomatis; and

b) Is approved for this purpose by the federal Food and Drug Administration.

"Multiple risk factors" means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy.

2) Human Papillomavirus Screening Test at the testing intervals outlined in the recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists.

"Human papillomavirus screening test" means any laboratory test that:

a) Specifically detects for infection by one or more agents of the human papillomavirus; and

b) Is approved for this purpose by the Federal Food and Drug Administration.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Nicotine Replacement Therapy Drugs

If the Policy provides benefits for Prescription Drugs, Benefits will be paid under the Prescription Drug Benefit for

1) any drug, except an over-the-counter drug, that is approved by the United States Food and Drug Administration as an aid for the cessation of the use of tobacco products; and that is obtained under a prescription written by an authorized prescriber; and

2) two 90-day courses of Nicotine Replacement Therapy per policy year.

"Nicotine replacement therapy" means a product that:

1) Is used to deliver nicotine to an individual attempting to cease the use of tobacco products; and

2) Is obtained under a prescription written by an authorized prescriber.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy the same as any other comparable prescription.

Benefits for Colorectal Cancer Screening

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for colorectal cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society (ACS).

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Prostate Cancer Screening

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for the expenses incurred in conducting a diagnostic examination which shall include a digital rectal exam and a prostate-specific antigen (PSA) test:

1) for men between the ages of 40 and 75;
2) when used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
3) when used for staging in determining the need for a bone scan in patients with prostate cancer; or
4) when used for men who are at high risk for prostate cancer.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Prescription Contraceptives

If benefits are provided for Prescription Drugs under this policy, benefits will be paid the same as any other Sickness for any contraceptive drug or device that is approved by the United States Food and Drug Administration for use as a contraceptive and that is obtained under a prescription written by an authorized Physician. In addition, benefits will be paid for the insertion or removal and any medical examination associated with the use of such contraceptive drug or device.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

This benefit does not restrict benefits otherwise provided under Preventive Care Services.

Benefits for Osteoporosis Prevention and Treatment

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for Bone Mass Measurement for the prevention, diagnosis, and treatment of osteoporosis when the Bone Mass Measurement is requested by a Physician for a Qualified Individual.

"Bone mass measurement" means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss.

"Qualified individual" means: 1) an estrogen deficient individual at clinical risk for osteoporosis; 2) an individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease; 3) an individual receiving long term glucocorticoid (steroid) therapy; 4) an individual with primary hyperparathyroidism; or 5) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Morbid Obesity

Benefits will be paid the same as any other surgery for surgical treatment of Morbid Obesity that is recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with criteria approved by the National Institutes of Health.

"Body mass index" means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

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 comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, diabetes, or any life-threatening or serious medical condition that is weight induced.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Hair Prostheses for Hair Loss Resulting from Chemotherapy or Radiation Treatment for Cancer

Benefits will be paid for one hair prosthesis when prescribed by a Physician for an Insured whose hair loss results from chemotherapy or radiation treatment for cancer. The benefit will be limited to $350.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits for Clinical Trial Costs

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for Patient Costs to an Insured in a clinical trial, as a result of:

1) treatment provided for a life-threatening condition; or
2) prevention, early detection, and treatment studies on cancer.

These benefits will be provided only if:

1) the treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any life-threatening condition;
2) the treatment is being provided in a clinical trial approved by:
   a) one of the National Institutes of Health (NIH);
   b) an NIH cooperative group or an NIH center;
   c) the FDA in the form of an investigational new drug application;
   d) the federal Department of Veterans Affairs; or
   e) an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutions of Health.
3) the facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
4) there is no clearly superior, noninvestigational treatment alternative; and
5) the available clinical or preclinical data provides a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Benefits will be paid for Patient Cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

"Patient cost" means the cost of a health care service that is incurred as a result of the treatment being provided to the Insured for purposes of the clinical trial.

Patient cost does not include:

1) the cost of an investigational drug or device;
2) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of the clinical trial;
3) costs associated with managing the research associated with the clinical trial; or
4) costs that are not covered under this policy for noninvestigational treatments.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Residential Crisis Services

Benefits will be paid the same as any other Sickness for Residential Crisis Services for treatment of mental illness.

"Residential Crisis Services" means intensive mental health and support services that are:

a) Provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the Insured's ability to function in the community;
b) Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
c) Provided out of the Insured's residence on a short-term basis in a community-based residential setting; and
d) Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide Residential Crisis Services.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Treatment of Mental Illness and Substance Use Disorder

Benefits will be paid the same as any other Sickness for the diagnosis and treatment of a mental illness and substance use disorder as specified below.

Inpatient Benefits

Inpatient benefits will be paid the same as any other Sickness for services provided in a Hospital on the same terms and conditions as for physical illness.

Partial Hospitalization Benefits

Partial Hospitalization benefits will be paid the same as any other Sickness for services provided in a Hospital on the same terms and conditions as for physical illness.

"Partial hospitalization" means the provision of medically directed intensive or intermediate short-term treatment:

a) to an Insured;
b) in a licensed or certified facility or program;
c) for mental illness, emotional disorders, drug abuse, or alcohol abuse; and
d) for a period of less than 24 hours but more than 4 hours in a day.

Outpatient Benefits

Outpatient benefits, including psychological and neuropsychological testing for diagnostic purposes provided to treat mental illness or substance use disorder, other than for Inpatient or Partial Hospitalization, will be paid the same as any other Sickness.

Medication management visits are payable as any other Sickness. The company will not charge a Copayment for methadone maintenance treatment that exceeds 50% of the daily cost of such treatment.

Benefits, including methadone maintenance treatment, shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Benefits for Treatment of Diabetes

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for all diabetes equipment, diabetes supplies and diabetes outpatient self-management training and educational services, including medical nutrition therapy, when the Insured's treating Physician or a Physician who specializes in the treatment of diabetes, or other appropriate licensed health care provider certifies that such services are for the treatment of: 1) insulin-using diabetes; 2) noninsulin-using diabetes; or 3) elevated blood glucose levels induced by pregnancy.

If certified by the treating Physician, the diabetes outpatient self-management training and educational services, including medical nutrition therapy, shall be provided to the Insured through a program supervised by a Physician or an appropriately licensed, registered, or certified health care provider whose scope of practice includes diabetes education or management.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Medical Foods and Modified Food Products

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for Medical Foods and Low Protein Modified Food Products for the treatment of Inherited Metabolic Diseases of a covered Dependent child if the Medical Foods or Low Protein Modified Food Products are:

1) Prescribed for the therapeutic treatment of inherited metabolic diseases; and
2) Administered under the direction of a Physician.

“Inherited metabolic disease” means a disease caused by an inherited abnormality of body chemistry and includes a disease for which the State screens newborn babies.

“Low protein modified food product” means a food product that is:

1) Specially formulated to have less than 1 gram of protein per serving; and
2) Intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

Low protein modified food product does not include a natural food that is naturally low in protein.

“Medical food” means a food that is:

1) Intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
2) Formulated to be consumed or administered enterally under the direction of a Physician.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy. Benefits shall be subject to the overall policy maximum benefit.

Benefits for Amino Acid-Based Elemental Formula

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for amino acid-based elemental formula, regardless of delivery method, for the diagnosis and treatment of:

1) immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
2) severe food protein induced enteroolitis syndrome;
3) eosinophilic disorders, as evidenced by the results of a biopsy; and
4) impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

These benefits will be provided upon written order by a Physician stating that the amino acid-based elemental formula is necessary for the treatment of a disease or disorder listed above.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations or any other provisions of the policy.

Benefits shall be subject to the overall policy maximum benefit.

Benefits for Prosthetic Devices

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for prosthetic devices, components of prosthetic devices and repairs to prosthetic devices.

"Prosthetic device" means an artificial device to replace, in whole or in part, a leg, an arm or an eye.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy. The Copayment or Coinsurance shall not exceed the Copayment or Coinsurance for primary care benefits.

Benefits for Orthopedic Braces

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for orthopedic braces.

"Orthopedic Brace" means a rigid or semirigid device that is used to

1. Support a weak or deformed body member; or
2. Restrict or eliminate motion in a diseased or injured part of the body.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy. Benefits shall be subject to the overall policy maximum benefit.

Benefits for Anesthesia for Dental Care

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for general anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care provided to an Insured that is:

1) 7 years of age or younger or is developmentally disabled;
2) an individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the Insured;
3) an individual for whom a superior result can be expected from dental care provided under general anesthesia; or

4) an extremely uncooperative, fearful, or uncommunicative child who is 17 years or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and

5) an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

These benefits must be provided by one of the following:

1) a fully accredited specialist in pediatric dentistry;

2) a fully accredited specialist in oral and maxillofacial surgery; or

3) a dentist to whom Hospital privileges have been granted.

This benefit does not cover charges for the dental care itself, only the charges for the general anesthesia and associated Hospital or ambulatory facility charges, nor does it apply to dental care rendered for temporal mandibular joint disorder (TMJ).

Benefits shall not be subject to limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Treatment of Cleft Lip and Cleft Palate

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for inpatient or outpatient expenses arising from orthodontics; oral surgery; otologic; audiological and speech/language treatment involved in the management of birth defects known as cleft lip and cleft palate or both.

Benefits shall not be subject to benefit limitations for specific types of services, but shall be subject to the overall policy maximum benefit. Benefits shall be subject to all Deductible, Copayment, Coinsurance, or any other provisions of the policy.

Benefits for Habilitative Services for Children

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for Habilitative Services for the Named Insured and Insured Dependents under the age of 19 years. Benefits will not be paid for Habilitative Services delivered through early intervention or school services.

“Habilitative services” means services, including occupational therapy, physical therapy, and speech therapy, for the treatment of a child with a Congenital or Genetic Birth Defect to enhance the child’s ability to function

“Congenital or genetic birth defect” means a defect existing at or from birth, including a hereditary defect. Congenital or genetic birth defect includes, but is not limited to, autism or an autism spectrum disorder and cerebral palsy.

This benefit is not subject to the limits for physical therapy, speech therapy, occupational therapy or benefit limitations for specific types of services, but is subject to all Deductible, Copayments, Coinsurance, or any other provisions of the policy.

Benefits shall be subject to the overall policy maximum benefit.

Benefits for Child Wellness

Benefits will be paid for that portion of charges which is not in excess of Usual and Customary Charges or Preferred Allowance for the following Child Wellness Services for a covered Dependent child:

1) All Physician's visits for and costs incurred for: a) childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention; b) collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age; and c) age-appropriate screening tests for tuberculosis; anemia; lead toxicity; hearing; and vision as determined by the American Academy of Pediatrics;
2) Universal hearing screening of newborns provided by a Hospital before discharge;
3) All visits for obesity evaluation and management; and
4) All visits for and costs of developmental screening as recommended by the American Academy of Pediatrics.

The following services at each of the Physician's visits described above are included:

1) A physical examination;
2) A developmental assessment;
3) Parental anticipatory guidance; and,
4) Any laboratory tests considered necessary by the Physician.

"**Child wellness services**" means a preventive activity designed to: 1) protect children from morbidity and mortality; and 2) promote child development. Such activities must be in keeping with: 1) prevailing medical standards; 2) public health policy; and 3) scientific evidence of effectiveness.

Benefits shall not be subject to the Deductible or benefit limitations for specific types of services, but are subject to Copayments, Coinsurance, or any other provisions of the policy. Benefits shall be subject to the overall policy maximum benefit

Benefits for Minor Child Hearing Aid

Benefits will be paid the same as any other Sickness for Hearing Aids for a minor child if the Hearing Aids are prescribed, fitted, and dispensed by a licensed audiologist. Benefits will not exceed $1,400 per Hearing Aid for each hearing-impaired ear every 36 months.

“Hearing Aid” means a device that is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children and is nondisposable.

Benefits shall be subject to all Deductible, Copayment, Coinsurance, limitations, or any other provisions of the policy.

Definitions

ADOPTED CHILD means the adopted child placed with an Insured while that person is covered under this policy. Such child will be covered from the moment of placement for the first 31 days. The Insured must notify the Company, in writing, of the adopted child not more than 30 days after placement or adoption.

In the case of a newborn adopted child, coverage begins at the moment of birth if a written agreement to adopt such child has been entered into by the Insured prior to the birth of the child, whether or not the agreement is enforceable. However, coverage will not continue to be provided for an adopted child who is not ultimately placed in the Insured’s residence.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's date of placement: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's date of placement.

COINSURANCE means the percentage of Covered Medical Expenses that the Company pays.

COMPLICATION OF PREGNANCY means a condition: 1) caused by pregnancy; 2) requiring medical treatment prior to, or subsequent to termination of pregnancy; 3) the diagnosis of which is distinct from pregnancy; and 4) which constitutes a classifiably distinct complication of pregnancy. A condition simply associated with the management of a difficult pregnancy is not considered a complication of pregnancy.

COPAY/COPAYMENT means a specified dollar amount that the Insured is required to pay for certain Covered Medical Expenses.

COVERED MEDICAL EXPENSES means: 1) that portion of charges which are not in excess of Usual and Customary Charges; 2) that portion of charges which are not in excess of the Preferred Allowance when the policy includes Preferred Provider benefits and the charges are received from a Preferred Provider; 3) that portion of charges which are not in excess of the maximum benefit amount payable per service as specified in the Schedule of Benefits; 4) made for services and supplies not excluded under the policy; 5) made for services included in the Schedule of Benefits.

Covered Medical Expenses will be deemed "incurred" only: 1) when the covered services are provided; and 2) when a charge is made to the Insured Person for such services.

CUSTODIAL CARE means services that are any of the following:

1) Non-health related services, such as assistance in activities.
2) Health-related services that are provided for the primary purpose of meeting the personal needs of the patient or maintaining a level of function (even if the specific services are considered to be skilled services), as opposed to improving that function to an extent that might allow for a more independent existence.
3) Services that do not require continued administration by trained medical personnel in order to be delivered safely and effectively.

DEDUCTIBLE means if an amount is stated in the Schedule of Benefits or any endorsement to this policy as a deductible, it shall mean the amount of Covered Medical Expenses that must be incurred by the Insured Person before becoming eligible for policy benefits. The deductible is subtracted from the amount or amounts otherwise payable as Covered Medical Expenses. The deductible will apply as specified in the Schedule of Benefits.

DEPENDENT means the spouse (husband or wife) or Domestic Partner of the Named Insured and their dependent children including a natural child, stepchild, Adopted Child, grandchild, child placed with the Insured for legal adoption or child for whom the Named Insured is under testamentary or court appointed guardianship, other than temporary guardianship of less than 12 months duration and a child for whom the Named Insured is under a court order to provide coverage. A dependent shall also mean a dependent of the Insured as the term is used in 26 U.S.C §§ 104, 105, 106, and any regulations adopted under those sections.

If the Named Insured is under a court order to provide coverage, the following apply:

1) the Insured will be allowed to include the child in the coverage regardless of any enrollment period restrictions;

2) if the Insured has coverage but does not include the child in the enrollment then:
   a) the noninsuring parent, child support enforcement agency, or the Department of Health and Mental Hygiene may apply for coverage on behalf of the child; and
   b) the child may obtain coverage regardless of any enrollment period restrictions.
3) coverage for the child may not be terminated unless the following written evidence is provided:
   a) the court order is no longer in effect;
   b) the child has been or will be enrolled under other reasonable health insurance coverage that will take effect on or before the effective date of the termination;
   c) the school has eliminated dependent coverage for all of its students; or
   d) the Insured is no longer a student.
4) if the child has coverage through an Insured parent, the Company will:
   a) provide membership cards or any other information necessary for the child to obtain benefits to the noninsuring parent; and
   b) process the claims and make appropriate payment to the noninsuring parent, health care provider, or Department of Health and Mental Hygiene if the noninsuring parent incurs expenses for health care provided to the child.

Children shall cease to be dependent at the end of the month in which they attain the age of 26 years. If the child is covered under this policy upon the attainment of the limiting age, such child shall remain a dependent under this policy at the option of the Named Insured until the policy Termination Date.

The attainment of the limiting age will not operate to terminate the coverage of such child while the child is and continues to be both:

1) Incapable of self-support because of mental or physical incapacity.
2) Chiefly dependent upon the Insured Person for support and maintenance.

Proof of such incapacity and dependency shall be furnished to the Company: 1) by the Named Insured; and, 2) within 31 days of the child's attainment of the limiting age. Subsequently, such proof must be given to the Company annually following the child's attainment of the limiting age.

If a claim is denied under the policy because the child has attained the limiting age for dependent children, the burden is on the Insured Person to establish that the child is and continues to be incapacitated as defined by subsections (1) and (2). The regular dependent premium will be charged to continue coverage for mentally or physically incapacitated dependent children.

DOMESTIC PARTNER means a person of the same or opposite sex who is neither married nor related by blood or marriage within four degrees of consanguinity to the Named Insured but who is: 1) the Named Insured's sole spousal equivalent; 2) lives together with the Named Insured in the same residence; and 3) contributes with the Named Insured for each other's welfare with the intention of remaining in the relationship indefinitely. Proof of a domestic partnership relationship can be demonstrated by one of the following common primary residence documents and one of the following financial interdependence documents:

a) Common Primary Residence Documents

1) a joint deed or mortgage agreement of the primary residence.
2) lease agreement showing common interest in primary residence.

3) Driver's license or State-issued identification listing a common address.
4) Utility or other household bill with both the Named Insured and the name of the domestic partner.

b) Financial Interdependence Documents

1) designation of the domestic partner as primary beneficiary for life insurance or retirement benefits.
2) designation of the domestic partner as primary beneficiary in the other partner's will.
3) powers of attorney for property and/or health care.
4) mutual valid written advance directive approving the other domestic partner as health care agent.
5) joint ownership of either a bank account or credit account.
6) joint ownership or holding of investments.
7) joint ownership or lease of a motor vehicle.

ELECTIVE SURGERY OR ELECTIVE TREATMENT means those health care services or supplies that do not meet the health care need for a Sickness or Injury. Elective surgery or elective treatment includes any service, treatment or supplies that: 1) are deemed by the Company to be research or experimental; or 2) are not recognized and generally accepted medical practices in the United States.

EMERGENCY SERVICES means, with respect to a Medical Emergency:

1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and
2) Such further medical examination and treatment to stabilize the patient, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)).

HOSPITAL means a licensed or properly accredited general hospital which: 1) is open at all times; 2) is operated primarily and continuously for the treatment of sick and injured persons as inpatients; 3) is under the supervision of a staff of one or more legally qualified Physicians available at all times; 4) continuously provides on the premises 24 hour nursing service by Registered Nurses; 5) provides organized facilities for diagnosis on the premises; and 6) is not primarily a clinic, nursing, rest or convalescent home.

HOSPITAL CONFINED/HOSPITAL CONFINEMENT means confinement as an Inpatient in a Hospital by reason of an Injury or Sickness for which benefits are payable.

IMMEDIATE FAMILY means husband, wife, Domestic Partner, children, father, mother, brother, sister, and the corresponding in-laws.

INJURY means bodily injury which is all of the following:

1) directly and independently caused by an accident which is unrelated to any pathological, functional, or structural disorder.
2) a source of loss.
3) treated by a Physician within 30 days after the date of accident.
4) sustained while the Insured Person is covered under this policy.

All related conditions and recurrent symptoms of the same or a similar condition will be considered one injury. Covered Medical Expenses incurred as a result of an injury that occurred prior to this policy's Effective Date will be considered a Sickness under this policy.

INPATIENT means an uninterrupted confinement that follows formal admission to a Hospital by reason of an Injury or Sickness for which benefits are payable under this policy.

INSURED PERSON means: 1) the Named Insured; and, 2) Dependents of the Named Insured, if: 1) the Dependent is properly enrolled in the program, and 2) the appropriate Dependent premium has been paid. The term "Insured" also means Insured Person.

INTENSIVE CARE means: 1) a specifically designated facility of the Hospital that provides the highest level of medical care; and 2) which is restricted to those patients who are critically ill or injured. Such facility must be separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient confinement. They must be: 1) permanently equipped with special life-saving equipment for the care of the critically ill or injured; and 2) under constant and continuous observation by nursing staff assigned on a full-time basis, exclusively to the intensive care unit. Intensive care does not mean any of these step-down units:

1) Progressive care.
2) Sub-acute intensive care.
3) Intermediate care units.
4) Private monitored rooms.
5) Observation units.
6) Other facilities which do not meet the standards for intensive care.

MAINTENANCE MEDICATION means a Prescription Drug anticipated to be used for six months or more to treat a chronic condition. Contact the Company to obtain a copy of the list of Maintenance Medications.

MEDICAL EMERGENCY means the occurrence of a sudden, serious and unexpected Sickness or Injury including the sudden and unexpected onset of a condition involving severe pain. In the absence of immediate medical attention, a reasonable person could believe this condition would result in any of the following:

1) Death.
2) Placement of the Insured's health in jeopardy.
3) Serious impairment of bodily functions.
4) Serious dysfunction of any body organ or part.
5) In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Expenses incurred for "Medical Emergency" will be paid only for Sickness or Injury which fulfills the above conditions. These expenses will not be paid for minor Injuries or minor Sicknesses.

MENTAL ILLNESS means a Sickness that is a mental, emotional or behavioral disorder listed in the mental health or psychiatric diagnostic categories in the current *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all mental health or psychiatric diagnoses are considered one Sickness.

NAMED INSURED means an eligible, registered student of the Policyholder, if: 1) the student is properly enrolled in the program; and 2) the appropriate premium for coverage has been paid.

NEWBORN INFANT means any child born of an Insured while that person is insured under this policy. Newborn Infants will be covered under the policy for the first 31 days after birth. Coverage for such a child will be for Injury or Sickness, including medically diagnosed congenital defects, birth abnormalities, prematurity and nursery care; benefits will be the same as for the Insured Person who is the child's parent.

The Insured will have the right to continue such coverage for the child beyond the first 31 days. To continue the coverage the Insured must, within the 31 days after the child's birth: 1) apply to us; and 2) pay the required additional premium, if any, for the continued coverage. If the Insured does not use this right as stated here, all coverage as to that child will terminate at the end of the first 31 days after the child's birth.

OUT-OF-POCKET MAXIMUM means the amount of Covered Medical Expenses that must be paid by the Insured Person before Covered Medial Expenses will be paid at 100% for the remainder of the Policy Year according to the policy Schedule of Benefits. The following expenses do not apply toward meeting the Out-of-Pocket Maximum, unless otherwise specified in the policy Schedule of Benefits:

1) Deductibles.
2) Copays.
3) Expenses that are not Covered Medical Expenses.

OUTPATIENT means outpatient and out-of-hospital medical services.

PHYSICIAN means a health care provider, including a Community Health Resource, as defined in s. 19-2101 of the Health—General Article, who is: 1) duly licensed under the Maryland Health Occupations Article or in accordance with the licensing requirements of the state in which the Covered Medical Expense is incurred; and 2) acting within his/her lawful scope of practice; and 3) not a member of the Insured Person's immediate family. Physicians who make referrals prohibited by §1-302 of Health Occupations Article will not be eligible for reimbursement.

The term "member of the immediate family" means any person related to an Insured Person within the third degree by the laws of consanguinity or affinity.

PHYSIOTHERAPY means any form of the following short-term rehabilitation therapies: physical or mechanical therapy; diathermy; ultra-sonic therapy; heat treatment in any form; manipulation or massage administered by a Physician.

POLICY YEAR means the period of time beginning on the policy Effective Date and ending on the policy Termination Date.

PRESCRIPTION DRUGS or Prescription Drug Product means a medication, product or device that has been approved by the U.S. Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug Product includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver. For the purpose of the benefits under the policy, this definition includes insulin.

REGISTERED NURSE means a professional nurse (R.N.) who is not a member of the Insured Person's immediate family.

SICKNESS means sickness or disease of the Insured Person which: 1) first manifests itself while the Insured Person is covered under this policy; and 2) causes incurred Covered Medical Expenses commencing while the Insured Person is covered under this policy. All related conditions and recurrent symptoms of the same or a similar condition will be considered one sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this policy's Effective Date will be considered a sickness under this policy.

SOUND, NATURAL TEETH means natural teeth, the major portion of the individual tooth is present, regardless of fillings or caps; and is not carious, abscessed, or defective.

SUBSTANCE USE DISORDER means a Sickness that is listed as an alcoholism and substance use disorder in the current Diagnostic and Statistical Manual of the American Psychiatric Association. The fact that a disorder is listed in the Diagnostic and Statistical Manual of the American Psychiatric Association does not mean that treatment of the disorder is a Covered Medical Expense. If not excluded or defined elsewhere in the policy, all alcoholism and substance use disorders are considered one Sickness.

TOTALLY DISABLED means a condition of a Named Insured which because of Sickness or Injury renders the Insured unable to actively attend classes. A totally disabled Dependent is one who is unable to perform all activities usual for a person of that age.

URGENT CARE CENTER means a facility that provides treatment required to prevent serious deterioration of the Insured Person's health as a result of an unforeseen Sickness, Injury, or the onset of acute or severe symptoms.

USUAL AND CUSTOMARY CHARGES means the lesser of the actual charge or a charge which is: 1) usual and customary when compared with the charges made for similar services and supplies; and 2) made to persons having similar medical conditions in the locality where service is rendered. The Company uses data from FAIR Health, Inc. to determine Usual and Customary Charges. If the policy includes Preferred Provider benefits, the usual and customary charge for services provided by an Out of Network provider will not be less than the Preferred Allowance for a similarly licensed Preferred Provider for the same service in the same geographic region. No payment will be made under this policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

Exclusions And Limitations

No benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; or b) treatment, services or supplies for, at, or related to any of the following:

1. Acupuncture;
2. Nicotine addiction, except as specifically provided in the policy; and caffeine addiction; non-chemical addiction to: gambling, sexual, spending, shopping, working and religious; codependency; except as specifically provided in the Benefits for Treatment of Mental Illness and Substance Use Disorder;
3. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation, except as specifically provided in the Benefits for Habilitative Services or Benefits for Treatment of Mental Illness and Substance Use Disorder;
4. Biofeedback;
5. Circumcision;
6. Congenital conditions, except as specifically provided for: Newborn and Adopted Infants; or under Benefits for Habilitative Services; Benefits for Treatment of Cleft Lip and Cleft Palate; Benefits for Amino Acid-Based Elemental Formula; or Benefits for Medical Foods and Modified Food Products;
7. Cosmetic procedures, except cosmetic surgery as determined by the treating Physician to be required to correct an Injury for which benefits are otherwise payable under this policy or for newborn or adopted children;
8. Custodial Care; care provided in: rest homes, health resorts, homes for the aged, halfway houses, college infirmaries or places mainly for domiciliary or Custodial Care; extended care in treatment or substance abuse facilities for domiciliary or Custodial Care;
9. Dental treatment, except for accidental Injury to Sound, Natural Teeth or as specifically provided in the Benefits for Anesthesia for Dental Care;
10. Elective Surgery or Elective Treatment;

11. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a covered Injury or disease process;
12. Flat foot conditions; supportive devices for the foot; fallen arches; weak feet; chronic foot strain; symptomatic complaints of the feet; and routine foot care including the care, cutting and removal of corns, calluses, toenails, and bunions (except capsular or bone surgery);
13. Health spa or similar facilities; strengthening programs;
14. Hearing examinations; hearing aids, except as specifically provided in the Benefits for Minor Child Hearing Aid; cochlear implants; or other treatment for hearing defects and problems, except as a result of an infection or trauma. "Hearing defects" means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
15. Hirsutism; alopecia;
16. Hypnosis;
17. Immunizations, except as specifically provided in the policy; preventive medicines or vaccines, except where required for treatment of a covered Injury or as specifically provided in the policy;
18. Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;
19. Injury sustained while (a) participating in any intercollegiate, or professional sport, contest or competition; (b) traveling to or from such sport, contest or competition as a participant; or (c) while participating in any practice or conditioning program for such sport, contest or competition;
20. Investigational services;
21. Lipectomy; except as specifically provided in Benefits for Morbid Obesity;
22. Prescription Drugs, services or supplies as follows:
    a) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use, except as specifically provided in the Benefits for Diabetes;
    b) Immunization agents, except as specifically provided in the policy, biological sera,;
    c) Drugs labeled, “Caution - limited by federal law to investigational use” or experimental drugs, except for Phase I, II, III or IV clinical trials for cancer, AIDS or other life-threatening conditions;
    d) Products used for cosmetic purposes;
    e) Drugs used to treat or cure baldness; anabolic steroids used for body building;
    f) Anorectics - drugs used for the purpose of weight control;
    g) Fertility agents or sexual enhancement drugs, such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene, or Viagra, except as specifically provided in the Benefits for In-Vitro Fertilization;
    h) Growth hormones; or
    i) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.
23. Reproductive/Infertility services including but not limited to: family planning; premarital examinations; impotence, organic or otherwise; female sterilization procedures, except as specifically provided in the policy; vasectomy; sexual reassignment surgery; reversal of sterilization procedures; except as specifically provided in the Benefits for In-Vitro Fertilization;
24. Research or examinations relating to research studies, or any treatment for which the patient or the patient’s representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research study or clinical research study, except as specifically provided in the policy;

25. Routine Newborn Infant Care, well-baby nursery and related Physician charges except as specifically provided in the policy;
26. Preventive care services; routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness; except as specifically provided in the policy;
27. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;
28. Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; deviated nasal septum, including submucous resection and/or other surgical correction thereof; nasal and sinus surgery, except for treatment of a covered Injury or treatment of chronic purulent sinusitis;
29. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
30. Sleep disorders;
31. Speech therapy, except as specifically provided in the Benefits for Habilitative Services for Children and Benefits for Cleft Lip and Cleft Palate; naturopathic services;
32. Supplies, except as specifically provided in the policy;
33. Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, except as specifically provided in the Benefits for Reconstructive Breast Surgery Following a Mastectomy; or gynecomastia;
34. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment; (except for institutions or Hospitals of the State of Maryland or any county or municipality thereof, whether such institutions or Hospital be deemed charitable, or otherwise);
35. War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
36. Except as specifically provided in the Benefits for Morbid Obesity and Benefits for Child Wellness, weight management, weight reduction, nutrition programs, treatment for obesity, and surgery for removal of excess skin or fat.

Collegiate Assistance Program

Insured Students have access to nurse advice, health information, and counseling support 24 hours a day, 7 days a week by dialing the number indicated on the permanent ID card. Collegiate Assistance Program is staffed by Registered Nurses and Licensed Clinicians who can help students determine if they need to seek medical care, need legal/financial advice or may need to talk to someone about everyday issues that can be overwhelming.

FrontierMEDEX: Global Emergency Services

If you are a student insured with this insurance plan, you and your insured spouse/Domestic Partner and minor child(ren) are eligible for FrontierMEDEX. The requirements to receive these services are as follows:

International Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible to receive FrontierMEDEX services worldwide, except in your home country.

Domestic Students, insured spouse/Domestic Partner and insured minor child(ren): You are eligible for FrontierMEDEX services when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

FrontierMEDEX includes Emergency Medical Evacuation and Return of Mortal Remains that meet the US State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All services must be arranged and provided by FrontierMEDEX; any services not arranged by FrontierMEDEX will not be considered for payment.

Key Services include:

*Transfer of Insurance Information to Medical Providers
*Transfer of Medical Records
*Worldwide Medical and Dental Referrals
*Emergency Medical Evacuation
*Transportation to Join a Hospitalized Participant
*Replacement of Corrective Lenses and Medical Devices
*Hotel Arrangements for Convalescence
*Return of Dependent Children
*Legal Referrals
*Message Transmittals
*Monitoring of Treatment
*Medication, Vaccine and Blood Transfers
*Dispatch of Doctors/Specialists
*Facilitation of Hospital Admission Payments
*Transportation After Stabilization
*Emergency Travel Arrangements
*Continuous Updates to Family and Home Physician
*Replacement of Lost or Stolen Travel Documents
*Repatriation of Mortal Remains
*Transfer of Funds
*Translation Services

Please visit www.firststudent.com for the FrontierMEDEX brochure which includes service descriptions and program exclusions and limitations.

To access services please call:

(800) 527-0218 Toll-free within the United States

(410) 453-6330 Collect outside the United States

Services are also accessible via e-mail at operations@frontiermedex.com.

When calling the FrontierMEDEX Operations Center, please be prepared to provide:

1. Caller's name, telephone and (if possible) fax number, and relationship to the patient;
2. Patient's name, age, sex, and FrontierMEDEX ID Number as listed on your Medical ID Card;
3. Description of the patient's condition;
4. Name, location, and telephone number of hospital, if applicable;
5. Name and telephone number of the attending physician; and
6. Information of where the physician can be immediately reached

FrontierMEDEX is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by FrontierMEDEX. Claims for reimbursement of services not provided by FrontierMEDEX will not be accepted. Please refer to the FrontierMEDEX information in MyAccount at www.firststudent.com for additional information, including limitations and exclusions.

Notice of Complaint Process for Coverage Decisions

Right to Internal Appeal

Standard Internal Appeal

The Insured Person has the right to request an Internal Appeal if the Insured Person disagrees with the Company's denial, in whole or in part, of a claim or request for benefits. The Insured Person, or the Insured Person's Authorized Representative, must submit a written request for an Internal Appeal within 180 days of receiving a notice of the Company's Coverage Decision.

The written Internal Appeal request should include:

1. A statement specifically requesting an Internal Appeal of the decision;
2. The Insured Person's Name and ID number (from the ID card);
3. The date(s) of service;
4. The Provider's name;
5. The reason the claim should be reconsidered; and
6. Any written comments, documents, records, or other material relevant to the claim.

Please contact the Customer Service Department at 800-505-4160 with any questions regarding the Internal Appeal process. The written request for an Internal Appeal should be sent to: Claims Appeals, UnitedHealthcare **Student**Resources, PO Box 809025, Dallas, TX 75380-9025.

Right to External Independent Review

After exhausting the Company's Internal Appeal process, the Insured Person, or the Insured Person's Authorized Representative, has the right to request an External Independent Review when the service or treatment in question:

1. Is a Covered Medical Expense under the Policy.

Standard External Review

A Standard External Review request must be submitted in writing within 4 months of receiving a notice of the Company's Appeal Decision or Final Appeal Decision.

Where to Send External Review Requests

All types of External Review requests shall be submitted to the state insurance department at the following address:

Claims Appeals
UnitedHealthcare **Student**Resources
PO Box 809025
Dallas, TX 75380-9025
888-315-0447

Questions Regarding Appeal Rights

Contact Customer Service with questions regarding the Insured Person's rights to an Internal Appeal and External Review.

Other resources are available to help the Insured Person navigate the appeals process. For questions about appeal rights, your state consumer assistance program may be able to assist you at:

Health Advocacy Unit of the Attorney General 200 St. Paul Place, 16th Floor
Baltimore, MD 21202
(410) 528-1840 or 1-877-261-8807
www.oag.state.md.us/Consumer/HEAU.htm
heau@oag.state.md.us

General Provisions

CLAIM FORMS: Claim forms are not required.

NOTICE OF CLAIM: Written notice of claim must be given to the Company within 90 days after the occurrence or commencement of any loss covered by this policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the Named Insured to the Company, P.O. Box 809025, Dallas, Texas 75380-9025 with information sufficient to identify the Named Insured shall be deemed notice to the Company. Failure to provide notice of claim within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish notice of claim within the time required and that notice of claim was submitted as soon as was reasonably possible.

PROOF OF LOSS: Written proof of loss must be furnished to the Company at its said office within 90 days after the date of such loss. Failure to furnish such proof within the time required will not invalidate nor reduce any claim if it was not reasonably possible to furnish proof within the time required and that proof or loss was submitted as soon as was reasonably possible. In no event except in the absence of legal capacity shall written proofs of loss be furnished later than one year from the time proof is otherwise required.

PAYMENT OF CLAIMS: All indemnities provided by this policy will be payable to the Named Insured unless the Named Insured requests in writing not later than the time of filing proofs of such loss that payment be made directly to the Hospital or person rendering such service. Any accrued indemnities unpaid at the Named Insured's death may, at the option of the Company, be paid to the estate of the Named Insured or to an Insured or beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay up to an amount not exceeding $5,000 to any relative by blood or connection by marriage of the Insured or beneficiary who is deemed by the Company to be equitably entitled thereto. Any payment so made shall discharge the Company's obligation to the extent of the amount of benefits so paid.

TIME OF PAYMENT OF CLAIM: Indemnities payable under this policy for any loss will be paid within 30 days upon receipt of due written proof of such loss.

Online Access to Account Information

UnitedHealthcare **Student**Resources Insureds have online access to claims status, EOBs, ID Cards, network providers, correspondence and coverage information by logging in to ***My Account*** at www.firststudent.com Insured students who don't already have an online account may simply select the "My Account" link. Follow the simple, onscreen directions to establish an online account in minutes using your 7-digit Insurance ID number or the email address on file.

As part of UnitedHealthcare **Student**Resources' environmental commitment to reducing waste, we've introduced a number of initiatives designed to preserve our precious resources while also protecting the security of a student's personal health information.

My Account has been enhanced to include *Message Center* - a self-service tool that provides a quick and easy way to view any email notifications we may have sent. In Message Center, notifications are securely sent directly to the Insured student's email address. If the Insured student prefers to receive paper copies, he or she may opt-out of electronic delivery by going into *My Email Preferences* and making the change there.

ID Cards

One way we are becoming greener is to no longer automatically mail out ***ID Cards***. Instead, we will send an email notification when the digital ID card is available to be downloaded from ***My Account***. An Insured student may also use ***My Account*** to request delivery of a permanent ID card through the mail. ID Cards may also be accessed via our mobile site at my.uhcsr.com.

UnitedHealth Allies

Insured students also have access to the UnitedHealth Allies® discount program. Simply log in to ***My Account*** as described above and select *UnitedHealth Allies Plan* to learn more about the discounts available. When the Medical ID card is viewed or printed, the UnitedHealth Allies card is also included. The UnitedHealth Allies Program is not insurance and is offered by UnitedHealth Allies, a UnitedHealth Group company.

Claim Procedure

In the event of Injury or Sickness, students should:

1) Report to the Student Health Service or Infirmary or to their Physician or Hospital for treatment.
2) Mail to the address below all medical and hospital bills along with the patient's name and insured student's name, address, SR ID number and name of the university under which the student is insured. A Company claim form is not required for filing a claim.
3) File claim within 90 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Failure to furnish bills within the time required will not invalidate or reduce any claim if it was not reasonably possible to furnish the proof of loss within the time required and that proof of loss was submitted as soon as reasonably possible. Bills submitted after one year and 90 days will not be considered for payment except in the absences of legal capacity.

The Plan is Underwritten by:

UnitedHealthcare Insurance Company

Submit all Claims and/or Customer Service Inquiries to:

First Student
P.O. Box 809025
Dallas, Texas 75380-9025
1-800-505-4160
or visit our website at www.firststudent.com

Please keep this Certificate as a general summary of the insurance. The Master Policy on file at the College contains all of the provisions, limitations, exclusions and qualifications of your insurance benefits, some of which may not be included in this Certificate. The Master Policy is the contract and will govern and control the payment of benefits.

This Certificate is based on Policy number 2013-376-82

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