STUDENT BLANKET HEALTH INSURANCE

Atlanta International Insurance Company, referred to in this Policy as “We,” “Us,” “Our” or “the Company,” issues this Policy to the Policyholder named in the Insurance Information Schedule to insure the students of a School.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred:
1. Due to a Covered Sickness or a Covered Injury; and
2. Sustained while the Policy is in force as hereinafter specifically provided.

We will pay the benefits under the terms of the Policy in consideration of:
1. The application for this Policy; and
2. The payment of all premiums as set forth in the Policy.

The Effective and Termination Dates for coverage under this Policy are as shown in the Schedule of Benefits and Rates. All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

The following pages form a part of this Policy as fully as if the signatures below were on each page.

This Policy is executed for the Company by its President and Secretary.

Andrew M. DiGiorgio, President

Angela Adams, Secretary

Non-Participating
Non-Renewable
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<td>External Review of Denial of Experimental or Investigative Treatment</td>
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</table>
INSURANCE INFORMATION SCHEDULE

POLICYHOLDER:  Clemson University
   Conway, South Carolina

POLICY NUMBER:  AIIC1718SCSHIP21

EFFECTIVE DATE:  August 1, 2017

TERMINATION DATE:  August 1, 2018

The Policy Year runs from the Policy Effective date until the Policy Termination Date. The Policy Term is the period of time selected and for which premium has been paid by an Eligible Student of the Policyholder.

PREMIUM SCHEDULE

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td></td>
<td>$2,729</td>
</tr>
<tr>
<td>Spouse Only</td>
<td></td>
<td>$2,729</td>
</tr>
<tr>
<td>Each Child(ren) Only *</td>
<td></td>
<td>$2,729</td>
</tr>
</tbody>
</table>

*If more than 3 children are to be covered as a Dependent on the plan, the rate will reflect a maximum of three (3) children.
SCHEDULE OF BENEFITS

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

Non-Preferred Provider: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Preferred Provider.

Deductible: Preferred Provider $750
Non-Preferred Provider $1,500

Prescription Drug Deductible: Combined Preferred and Non-Preferred $100

Out-of-Pocket Maximum: Preferred Provider: Individual $6,350
Family $12,700
Non-Preferred Provider: Individual $15,000
Family $30,000

Coinsurance Amount:
Preferred Provider: 80% of the Preferred Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Preferred Provider: 70% of the Usual and Reasonable charge for Covered Medical Expenses unless otherwise stated below.

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

Preferred Provider Organization:
To locate a Cigna Provider in Your area, consult Your Provider Directory or visit our website at www.cigna.com.

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

<table>
<thead>
<tr>
<th>BENEFITS FOR COVERED INJURY/SICKNESS</th>
<th>STUDENT HEALTH CENTER</th>
<th>PREFERRED PROVIDER</th>
<th>NON-PREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Room &amp; Board Expenses</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Up to the Semi-Private Room Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-certification required</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expense Description</td>
<td>Pre-certification Required</td>
<td>Allowedance Type</td>
<td>Coverage Type</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------</td>
<td>----------------------------</td>
<td>--------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>Hospital Intensive Care Unit Expense - <em>in lieu of normal Hospital Room &amp; Board Expenses</em></td>
<td>Pre-certification required</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses for services &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</td>
<td>Pre-certification required</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Physician’s Visits while Confined: Limited to one per day of Confinement</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Inpatient Surgery:</td>
<td></td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Registered Nurse Services for private duty nursing while Confined</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Physical Therapy (inpatient)</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Skilled Nursing Facility Expense Benefit</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Mental Health Disorder Benefit</td>
<td>N/A</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Substance Use Disorder Benefit</td>
<td>N/A</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
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<tr>
<td>Outpatient Benefits</td>
<td></td>
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<tr>
<td>---------------------------------------------------------</td>
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<td>---</td>
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</tr>
<tr>
<td><strong>Outpatient Surgery</strong>:</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Surgeon Services</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td><strong>Outpatient Surgery Miscellaneous</strong></td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>(excluding not-scheduled surgery) – expenses for services &amp; supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood &amp; plasma</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td><strong>Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, Physical Therapy, occupational therapy and speech therapy</strong></td>
<td>100% of Preferred Allowance for Covered Medical Expenses</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Physical Therapy and Occupational therapy subject to combined limit of Unlimited visits per Policy Year</td>
<td>Copayment: $20 for Physical Therapy</td>
<td>Copayment: $25</td>
<td>Copayment: $40</td>
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<tr>
<td>Speech Therapy limited to Unlimited visits per Policy Year</td>
<td>Copayment: $20 for all other Therapies</td>
<td>Deductible Waived</td>
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<td>Habilitative Services are covered to the extent that they are Medically Necessary</td>
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<td></td>
<td></td>
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<td><strong>Emergency Services Expenses</strong></td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<td></td>
<td>Copayment: $450</td>
<td>Copayment: $450</td>
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<td></td>
<td>Copayment waived if admitted</td>
<td>Copayment waived if admitted</td>
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<td>Benefit 1</td>
<td>Benefit 2</td>
<td>Benefit 3</td>
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<tr>
<td>In Office Physician’s Visits includes care by primary Physician, and specialist</td>
<td>100% of Preferred Allowance</td>
<td>80% of Preferred Allowance</td>
<td>70% of Usual and Reasonable Charge</td>
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<td></td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
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<td></td>
<td>Copayment: $20</td>
<td>Copayment: $25</td>
<td>Copayment: $40</td>
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<td>Deductible Waived</td>
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<td>Second Opinion Benefit</td>
<td>N/A</td>
<td>80% of Preferred Allowance</td>
<td>70% of Usual and Reasonable Charge</td>
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<td></td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
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<tr>
<td></td>
<td></td>
<td>Copayment: $25</td>
<td>Copayment: $40</td>
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<tr>
<td>Urgent Care Centers or Facilities</td>
<td>N/A</td>
<td>80% of Preferred Allowance</td>
<td>70% of Usual and Reasonable Charge</td>
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<td></td>
<td></td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
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<tr>
<td></td>
<td></td>
<td>Copayment: $75</td>
<td>Copayment: $75</td>
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<td>Outpatient Facility Fee</td>
<td>N/A</td>
<td>80% of Preferred Allowance</td>
<td>70% of Usual and Reasonable Charge</td>
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<td></td>
<td></td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
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<tr>
<td></td>
<td></td>
<td>Copayment: $75</td>
<td>Copayment: $75</td>
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<td>Diagnostic Imaging Services</td>
<td>100% of Preferred Allowance</td>
<td>80% of Preferred Allowance</td>
<td>70% of Usual and Reasonable Charge</td>
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<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived</td>
<td>Copayment: $25</td>
<td>Copayment: $40</td>
</tr>
<tr>
<td>CT Scan, MRI and/or PET Scans</td>
<td>N/A</td>
<td>80% of Preferred Allowance</td>
<td>70% of Usual and Reasonable Charge</td>
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<td></td>
<td></td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
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<tr>
<td></td>
<td></td>
<td>Copayment: $150</td>
<td>Copayment: $300</td>
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<tr>
<td>Laboratory Procedures (Outpatient)</td>
<td>100% of Preferred Allowance</td>
<td>80% of Preferred Allowance</td>
<td>70% of Usual and Reasonable Charge</td>
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<tr>
<td></td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived</td>
<td>Copayment: $25</td>
<td>Copayment: $40</td>
</tr>
<tr>
<td>Prescription Drugs  Non-Preferred Provider benefits are provided on a reimbursement</td>
<td>80% of Preferred Allowance</td>
<td>80% of Preferred Allowance</td>
<td>80% of Usual and Reasonable Charge</td>
</tr>
<tr>
<td>basis. Claim forms must be received within 90 days.</td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
<td>for Covered Medical Expenses</td>
</tr>
<tr>
<td></td>
<td>Copayment: $10</td>
<td>Copayment: $20</td>
<td>Copayment: $20</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived</td>
<td>Generic</td>
<td>Generic</td>
</tr>
<tr>
<td>Service Description</td>
<td>Preferred Brand Copayment:</td>
<td>Specialty Drug Copayment:</td>
<td>Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Home Health Care Expenses</td>
<td>100%</td>
<td>80%</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospice Care Coverage</td>
<td>100%</td>
<td>80%</td>
<td>N/A</td>
</tr>
<tr>
<td>Private Duty Nursing by a Registered Nurse</td>
<td>100%</td>
<td>80%</td>
<td>N/A</td>
</tr>
<tr>
<td>Mental Health Disorder Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Substance Use Disorder Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Other Benefits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>100% of Preferred Allowance for Covered Medical Expenses</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>N/A</td>
</tr>
<tr>
<td>Allergy Injections/Treatment</td>
<td>100% of Preferred Allowance for Covered Medical Expenses</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>N/A</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>N/A</td>
<td>80%</td>
<td>N/A</td>
</tr>
<tr>
<td>Service</td>
<td>Coverage</td>
<td>Benefit</td>
<td>Copayment</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>----------</td>
<td>---------</td>
<td>-----------</td>
</tr>
<tr>
<td>Braces and Appliances</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Durable Medical Equipment - Includes Prosthetic Devices</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Nutritional Counseling</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Consultant/Specialist Physician Services</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Copayment: $25</td>
<td></td>
<td></td>
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<tr>
<td>Covered Clinical Trials</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Insured Person’s over age 18</td>
<td></td>
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<tr>
<td>Sickness Dental Expense for Insured Persons over age 18 Subject to $750 per tooth</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Non-emergency Care While Traveling Outside of the United States</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
<td></td>
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<tr>
<td>Medical Evacuation Expense</td>
<td>100% Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Repatriation Expense</td>
<td>100% Usual and Reasonable Charge for Covered Medical Expenses</td>
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</tr>
<tr>
<td>Pediatric Dental Care Benefit</td>
<td>N/A</td>
<td>See Benefit for limitations</td>
<td>See Benefit for limitations</td>
</tr>
<tr>
<td>Preventive Dental Care Limited to 1 dental exams every 6 months</td>
<td></td>
<td>100% of Usual and Reasonable Charge for Preventive Dental Care</td>
<td>100% of the Usual and Reasonable Charge for Preventive Services</td>
</tr>
<tr>
<td>Preventive Dental Care:</td>
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<tr>
<td>Emergency Dental</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>Routine Dental Care</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>Endodontic Services</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>Prosthodontic Services</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<tr>
<td>Medically Necessary Orthodontic Care</td>
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<tr>
<td>50% Usual and Reasonable</td>
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<td>50% Usual and Reasonable</td>
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<tr>
<td>Dental Care Benefit</td>
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<tr>
<td>Preventive Dental Care</td>
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<tr>
<td>Limited to 1 dental exams every 6 months</td>
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<td>N/A</td>
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<tr>
<td>See Benefit for limitations</td>
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<tr>
<td>See Benefit for limitations</td>
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<tr>
<td>The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:</td>
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<tr>
<td>Routine Dental Care</td>
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<tr>
<td>80% Usual and Reasonable</td>
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<tr>
<td>80% Usual and Reasonable</td>
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<tr>
<td>Pediatric Vision Care Benefit</td>
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<tr>
<td>Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames per Policy Year</td>
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<tr>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Adult Vision Care</td>
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<tr>
<td>Routine Eye Exam once every 12 months and 1 pair of prescribed lenses and frames per 12-month period</td>
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<tr>
<td>N/A</td>
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<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Adult Vision Care</td>
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<tr>
<td>Routine Eye Exam once every 12 months and 1 pair of prescribed lenses and frames per 12-month period</td>
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<td>N/A</td>
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<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Chiropractic Care Benefit</td>
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<td>N/A</td>
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<tr>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
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<tr>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<td>Organ Transplant Surgery</td>
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<td>N/A</td>
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<tr>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
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<tr>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Dialysis Care</td>
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<td>N/A</td>
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<tr>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
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<tr>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
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<tr>
<td>Copayment: $25</td>
<td></td>
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<tr>
<td>Copayment: $40</td>
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</tr>
<tr>
<td>Chemotherapy and Radiation Therapy</td>
<td>N/A</td>
<td>80% of Preferred Allowance for Covered Medical Expenses</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
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<td>---------------------------------------------------------------</td>
</tr>
</tbody>
</table>

**Mandated Benefits**

<table>
<thead>
<tr>
<th>Autism Spectrum Disorder</th>
<th>Same as any other Covered Sickness, subject to the limitations described in the benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer Diagnosis Coverage</td>
<td>Same as any other Preventive Service</td>
</tr>
<tr>
<td>Cleft Lip and Palate Coverage</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Diabetes Coverage</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Mastectomy Coverage</td>
<td>Same as any other Covered Sickness</td>
</tr>
</tbody>
</table>
SECTION I - ELIGIBILITY

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

Each Eligible Student is eligible for Coverage under this Policy. Except in the case of medical withdrawal due to Sickness or Injury, any Student withdrawing from school during the first thirty-one (31) days of the period for which Coverage is purchased, will not be covered under this Policy and a full refund of Premium will be made minus the cost of any claim Benefits made by Us. Students withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed.

SECTION II - POLICY YEAR, PREMIUM AND PREMIUM PAYMENT

Policy Year: This Policy takes effect and terminates on the corresponding dates shown in the Insurance Information Schedule. All time periods begin and end at 12:01 A.M., local time, at the address of the Policyholder.

Premium and Premium Payment: Premium for the Policy will be calculated on the basis of the rates stated in the Premium Schedule.

The Policyholder agrees to submit to Us or Our duly authorized agent the name, Effective Date and any other required eligibility information for each person becoming insured hereunder. This must be done within 30 days after the Effective Date of each Insured Person's coverage. The information, together with payment of the premium due for such persons, must be submitted.

If We or Our duly authorized agent do not receive this information within this 30 day period, coverage on any names submitted subsequent to that period will not take effect until the date We actually receive the name of the person to be insured. Coverage is also subject to payment of any premium due.

Grace Period: The Policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the coverage shall continue in force.

Refund of Premium: Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:
1. For any student who does not attend school during the first thirty (30) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium will be made.
2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

No other refunds will be allowed.

SECTION III - EFFECTIVE AND TERMINATION DATES

Effective Dates: Insurance under this Policy will become effective on the later of:
1. The Policy Effective Date;
2. The beginning date of the term for which premium has been paid;
3. The day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School; or
4. The day after the date of postmark if the Enrollment Form is mailed.

Dependent’s coverage, under the Voluntary Participation Basis, becomes effective on the later of:
1. The day after the date of postmark when the Enrollment Form is mailed; or
2. The beginning date of the term for which premium has been paid; or
3. The day after the date the required individual Enrollment Form and premium payment are received by Us or Our
authorized agent. This applies only when premium payment is made within 31 days of the student’s enrollment in the School’s insurance plan; or
4. The Policy Effective Date.

The last date for enrollment is shown in the Insurance Information Schedule. The Enrollment Period will run from the start of the quarter or semester for which coverage is desired.

**Qualifying Life Event** that qualifies an Insured Student to apply for include:

1. Marriage;
2. Loss of a spouse; whether by death, divorce, annulment or legal separation;
3. Birth or adoption of a child, or acquiring a child through marriage;
4. A change in the benefit plan available to the Insured Student’s spouse; and
5. Termination of the Insured Student’s spouse employment.

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

1. The date this Policy terminates for all Insured Persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date an Insured Person ceases to be eligible for the insurance; or
4. The date an Insured Person enters military service; or
5. For International Students, the date the student ceases to meet Visa requirements;
6. On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error and subject to the Grace Period provision.

**Dependent Child Coverage:**

**Newly Born Children** - A newly born child of an Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and Treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth. If an additional premium is required, to continue coverage beyond this initial 31-day period, the Insured Student must notify Us of the birth so We can generate an updated premium bill so a timely premium payment is made. If an additional premium is not required, We request that the Insured Student notify Us of the birth to ensure proper claims adjudication.

**Adopted Children** - Dependent Child Coverage also applies to any child adopted or placed for adoption irrespective of whether the adoption has become final.

We must receive:
1. Notification of a child’s placement for adoption within 31 days of the placement; and
2. Any premium required for the child.

We will provide coverage for the child placed for adoption as long as the Insured Person:

1. Has custody of the child;
2. The Insured Student’s coverage under this policy remains in effect; and
3. The required premiums are furnished to Us.

As it pertains to this provision:

**Child** means, in connection with an adoption or place for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

**Placement for adoption** means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child’s placement with a person terminates upon the termination of the legal obligation.

**Handicapped Children:** If:
1. There is Dependent coverage; and
2. The Policy provides that coverage of a Dependent child will terminate upon attainment of a specified age. We will not terminate the coverage of such child due attainment of that age while the child is and continues to be both:
   1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
   2. Chiefly dependent upon the Insured Student for support and maintenance.

Proof of such incapacity and dependence shall be furnished to us within thirty-one days of the child's attainment of the limiting age. Upon request, We may require proof satisfactory to it of the continuance of such incapacity and dependency. We may not request this more frequently than annually after the two-year period following the child's attainment of the limiting age.

**Extension of Benefits:** Coverage under this Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows:
- If an Insured Person is Hospital Confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to 90 days from the Termination Date while such Confinement continues.

Dependents that are newly acquired during the Insured Person’s Extension of Benefits period are not eligible for benefits under this provision.

**Continuous Coverage:** Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under this Policy:
1. When premium payment is received either in Our Home Office or by Our Agent or the Plan Administrator; and
2. Premium is received within the Enrollment Period specified in the Insurance Information Schedule.

This is regardless of any breaks in calendar days between consecutive periods of insurance.

**Reinstatement Of Reservist After Release From Active Duty:** If an Insured Person’s insurance or an eligible Dependent’s insurance ends due to the Insured Person being called or ordered to active duty, such insurance will be reinstated without any waiting period when the Insured Person returns to School and satisfies the eligibility requirements defined by the School or College.

SECTION IV – DEFINITIONS

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

**Accident** means a sudden, unforeseeable external event which directly and from no other cause results in an Injury to the Insured Person.

**Ambulance Service** means transportation to and from a Hospital by a licensed Ambulance whether a ground or air Ambulance, in a medical emergency.

**Ambulatory Surgical Center** means a facility which meets licensing and other legal requirements and which:
1. Is equipped and operated to provide medical care and Treatment by a Physician;
2. Does not provide services or accommodations for overnight stays;
3. Has a medical staff that is supervised full-time by a Physician;
4. Has full-time services of a licensed Registered Nurse at all times when patients are in the facility;
5. Has at least one operating room and one recovery room and is equipped to support any surgery performed;
6. Has x-ray and laboratory diagnostic facilities;
7. Maintains a medical record for each patient; and
8. Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need Confinement.

**Anesthetist** means a Physician or Nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.
**Assistant Surgeon** means a Physician who assists the Surgeon who actually performs a surgical procedure.

**Brand Name Drugs** means drugs for which the drug manufacturer’s trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

**Coinsurance** means the ratio by which We and the Insured Person share in the payment of Usual and Reasonable expenses for Treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits. The Coinsurance is separate and not part of the Deductible and Copayment.

**Complications of Pregnancy** means conditions that require Hospital Confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

**Confinement/Confined** means an uninterrupted stay following admission to a health care facility. The readmission to a health care facility for the same or related condition, within a seventy-two (72) hour period, will be considered a continuation of the Confinement. Confinement does not include observation, which is a review or assessment of eighteen (18) hours or less, of an Insured Person’s condition that does not result in admission to a Hospital or health care facility.

**Copayment** means a specified dollar amount an Insured Person must pay for specified Covered Medical Expenses. Any Copayment amounts are shown in the Schedule of Benefits.

**Country of Assignment** means the country in which an Eligible International Student, scholar or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

**Covered Injury or Injury** means a bodily injury due to an unforeseeable, external event which results independently of disease, bodily infirmity or any other cause that is:

1. Sustained by an Insured Person while he/she is insured under this Policy or the School’s prior policies; and
2. Caused by an accident directly and independently of all other causes.

Coverage under the School’s policies must have remained continuously in force:

1. From the date of Injury; and
2. Until the date services or supplies are received, for them to be considered as a Covered Medical Expense under this Policy.

All Injuries sustained in any one (1) Accident, all related conditions and recurrent symptoms of these Injuries are considered a single Injury.

**Covered Medical Expense** means those charges for any Treatment, service or supplies that are:

1. Not in excess of the Usual and Reasonable charges therefore;
2. Not in excess of the charges that would have been made in the absence of this insurance;
3. Not in excess of the Preferred Allowance; and
4. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

**Covered Sickness** means an illness, disease or condition including pregnancy and Complications of Pregnancy that
impairs an Insured Person’s normal function of mind or body and which is not the direct result of an Injury which:
1. Causes a loss while the Policy is in force; and
2. Which results in Covered Medical Expenses.
Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

**Custodial Care** means care that is mainly for the purpose of meeting non-medical personal needs. This includes help with activities of daily living and taking medications. Activities of daily living include: bathing, dressing or grooming, eating, toileting, walking and getting in and out of bed. Custodial Care can usually be provided by someone without professional and medical skills or training.

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

**Dependent** means:
1. An Insured Student’s lawful spouse or lawful Domestic Partner;
2. An Insured Student’s dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student’s unmarried biological or adopted child or stepchild who has reached age 26 and who is:
   a. primarily dependent upon the Insured Student for support and maintenance; and
   b. incapable of self-sustaining employment by reason of intellectual disability, mental illness or disorder or physical handicap.
   Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

**Durable Medical Equipment** means a device which:
1. Is primarily and customarily used for medical purposes, is specially equipped with features and functions that are generally not required in the absence of Sickness or Injury and is able to withstand repeated use;
2. Is used exclusively by the Insured Person;
3. Is routinely used in a Hospital but can be used effectively in a non-medical facility;
4. Can be expected to make a meaningful contribution to treating the Insured Person’s Sickness or Injury; and
5. Is prescribed by a Physician and the device is Medically Necessary for rehabilitation.

Durable Medical Equipment does not include:
1. Comfort and convenience items;
2. Equipment that can be used by Immediate Family Members other than the Insured Person;
3. Health exercise equipment; and
4. Equipment that may increase the value of the Insured Person’s residence.

**Effective Date** means the date coverage becomes effective.

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

**Elective Surgery** includes, but is not limited to, circumcision, sterilization reversal, breast reduction, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary Treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

**Elective Treatment** means care not considered a Medically Necessary essential health benefit. Such Treatment is typically undertaken to achieve advantage for the Insured Person but is not urgent or essential to life or health. Elective Treatment includes, but is not limited to, Treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the Treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law.
Eligible Student means a student who meets all eligibility requirements of the School named as the Policyholder or Dependent of the Insured Student.

Emergency Medical Condition means a Covered Sickness or Injury for which immediate medical Treatment is sought at the nearest available facility. The Condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:
1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

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

Essential Health Benefits mean benefits that are defined in Section 1302(b) of the Patient Protection and Affordable Care Act and as further defined by the Secretary of the United States Department of Health and Human Services and includes the following categories of covered services:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and Substance Use Disorder services, including behavioral health Treatment;
6. Prescription drugs;
7. Rehabilitative and Habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Experimental/Investigative means the service or supply has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication. For further explanation, see the Medically Necessary/Medical Necessity provision.

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

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

Habilitation/Habilitative Services means health care services that help the Insured Person keep, learn, or improve skills and functions for daily living. Examples include therapy for a child who is not walking or talking at the expected age. Habilitative Services may include such services as Physical Therapy, occupational therapy, speech therapy and other services for Insured Persons with disabilities in a variety of inpatient and/or outpatient settings.

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

Hospice means a coordinated plan of home and inpatient care which treats the terminally ill patient and family as a unit. It provides care to meet the special needs of a family unit during the final stages of a terminal Illness and during the bereavement. Care is provided by a team of: trained medical personnel, homemakers, and counselors. The team acts under an independent Hospice administration. It helps the family unit cope with: physical, psychological, spiritual,
social, and economic stresses.

**Hospital** means a facility which provides diagnosis, Treatment, and care of persons who need acute Inpatient Hospital care under the supervision of Physicians and provides 24-hour nursing service by Registered Nurses on duty or call. It must be licensed as a general acute care Hospital according to state and local laws. Hospital shall also include a psychiatric health facility for the Treatment of mental or psychoneurotic disorders. Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital also includes an Ambulatory Surgical Center or ambulatory medical center; and a birthing facility certified and licensed as such under the laws where located. It shall also include Rehabilitative facilities if such is specifically required for Treatment of physical disability.

Facilities primarily treating drug addiction or alcoholism that are licensed to provide these services are also included in this definition. Hospital does not include a place primarily for rest, the aged, a place for educational or Custodial Care or Hospice.

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

**Insured Person** means an Insured Student or Dependent of an Insured Student while insured under this Policy.

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

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

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

**Loss** means medical expense caused by an Injury or Sickness which is covered by this Policy.

**Medically Necessary** or **Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide to an Insured Person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the Insured Person's illness, injury or disease; and
3. Not primarily for the convenience of the Insured Person, Physician or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or Treatment of that Insured Person's illness, injury or disease.

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

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

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

**Nurse** means a licensed Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) who:
1. Is properly licensed or certified to provide medical care under the laws of the state where the Nurse practices; and
2. Provides medical services which are within the scope of the Nurse’s license or certificate who does not ordinarily
reside in the Insured Person’s home or is not related to the Insured Person by blood or marriage.

**Organ Transplant** means the moving of an organ from one body to another or from a donor site to another location of the person’s own body, to replace the recipient’s damaged, absent or malfunctioning organ.

**Out-of-Pocket Maximum** means the most an Insured Person will pay during a Policy Year before their coverage begins to pay 100% of the allowed amount. This limit will never include premium, balance-billed charges or health care this policy does not cover. The Insured Person’s Non-Preferred Provider payments or other non-covered expenses and Elective Treatment do not count toward this limit.

**Organ Transplant** means the moving of an organ from one body to another or from a donor site to another location of the person’s own body, to replace the recipient’s damaged, absent or malfunctioning organ.

**Out-of-Pocket Maximum** means the most an Insured Person will pay during a Policy Year before their coverage begins to pay 100% of the allowed amount. This limit will never include premium, balance-billed charges or health care this policy does not cover. The Insured Person’s Non-Preferred Provider payments or other non-covered expenses and Elective Treatment do not count toward this limit.

**Physical Therapy** means any form of the following:
1. Physical or mechanical therapy;
2. Diathermy;
3. Ultra-sonic therapy;
4. Heat Treatment in any form; or
5. Manipulation or massage.

**Physician** means a health care professional practicing within the scope of his or her license and is duly licensed by the appropriate state regulatory agency to perform a particular service which is covered under this policy, and who is not:
1. The Insured Person;
2. An Immediate Family Member; or
3. A person employed or retained by the Insured Person.

**Preadmission Testing** means tests done in conjunction with and within 5 days of a scheduled surgery where an operating room has been reserved before the tests are done.

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

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

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

**Prosthetic Devices** are artificial replacement body parts needed to ease or correct a condition caused by an illness, injury or birth defect, disease or anomaly.

**Qualifying Life Event** means an event that qualifies an Insured Student to apply for coverage the Insured Student’s Dependent due to a Qualifying Life Event under this Policy.

**Rehabilitative** means the process of restoring an Insured Person’s ability to live and work after a disabling condition by:
1. Helping the Insured Person achieve the maximum possible physical and psychological fitness;
2. Helping the Insured Person regain the ability to care for himself or herself;
3. Offering assistance with relearning skills needed in everyday activities, with occupational training and guidance with psychological readjustment.

**Reservist** means a member of a reserve component of the Armed Forces of the United States. Reservists also include a member of the State National Guard and the State Air National Guard.

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

**Skilled Nursing Facility** – a facility, licensed, and operated as set forth in applicable state law, which:
1. mainly provides inpatient care and Treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or Treatment of alcohol or drug
dependency; and
5. is not a rest, educational, or custodial facility or similar place.

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

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

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

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

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

**Surgeon** means a Physician who actually performs surgical procedures.

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

**Urgent Care** means short-term medical care performed in an Urgent Care Facility for non-life-threatening conditions that
can be mitigated or require care within forty-eight (48) hours of onset.

**Urgent Care Facility** means a Hospital or other licensed facility which provides diagnosis, Treatment, and care of
persons who need acute care under the supervision of Physicians.

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

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

**We, Us, or Our** means Atlanta International Insurance Company or its authorized agent. Also referred to as the
Company.

**SECTION V - STUDENT HEALTH CENTER REFERRAL**

This is a supplemental plan. Where available, the student must first use the resources of the Student Health Center (SHC)
where Treatment will be administered or a referral issued that verifies that the services were not available at the SHC. The
Insured Person is then free to seek services outside the SHC. Expenses incurred for medical Treatment rendered outside of
the SHC for which no prior approval or referral is obtained will be paid per the Schedule of Benefits. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary **ONLY** under the following conditions:
1. For an Emergency Medical Condition. The student must return to the SHC for necessary follow-up care;
2. When the SHC is closed;
3. For medical care received when the student is more than 30 miles from campus;
4. For medical care obtained when a student is no longer able to use the SHC due to a change in student status;
5. For maternity care;
6. When service is rendered at another facility during break or vacation period;
7. Mental Health Disorders.

A written referral from the SHC is recommended for any follow-up care, with a Provider other than the SHC, after Emergency services. An SHC referral does not constitute a guarantee of Benefits when Treatment is provided outside the SHC.

Dependent children are not eligible to use the SHC and are exempt from the above limitation and requirements.

**SECTION VI - DESCRIPTION OF BENEFITS**

**Benefit Payments for Preferred Providers and Non-Preferred Providers**
This Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. This Policy provides access to both Preferred Providers and Non-Preferred Providers. Different benefits may be payable for Covered Medical Expenses rendered by Preferred Providers versus Non-Preferred Providers, as shown in the Schedule of Benefits.

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

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

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

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

If the Insured Person is undergoing an active course of Treatment with a Preferred Provider, the Insured Person may request continuation of Treatment by such Preferred Provider in the event the Preferred Provider’s contract has terminated with the Preferred Provider organization. We shall notify the Insured Person of the termination of the Preferred Provider’s contract at least 60 days in advance. When circumstances related to the termination render such notice impossible, We shall provide affected enrollees as much notice as is reasonably possible. The notice given must include instructions on obtaining and alternate provider and must offer Our assistance with obtaining an alternate provider and ensuring that there is no inappropriate disruption in the Insured Person’s ongoing Treatment. We shall permit the Insured Person to continue to be covered, with respect to the course of Treatment with the provider, for a transitional period of at least 60 days from
the date of the notice to the Insured Person of the termination except that if an Insured Person is in the second trimester of pregnancy at the time of the termination and the provider is treating the Insured person during the pregnancy. The transitional period must extend through the provision of postpartum care directly related to the pregnancy.

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

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

Treatment of Covered Injury or Covered Sickness:
We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to Covered Injury or Covered Sickness. Benefits payable are subject to:
1. Any specified benefit maximum amounts;
2. Any Deductible amounts;
3. Any Coinsurance amount;
4. Any Copayments;
5. The Out-of-Pocket Maximum; and
6. Use of Preferred Provider, if any.

The following are shown in the Schedule of Benefits:
- Deductible
- Any specified benefit maximums
- Coinsurance percentages
- Copayment amounts
- Out-of-Pocket Maximums

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

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

Payment will be made, Subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits:
1. For the Usual and Reasonable Charges or the Preferred Allowance for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

**Covered Medical Expenses**
We will pay the Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness.

**Pre-Certification Process**
The Insured Person is responsible for calling Us at the phone number found on the back of the Insured Person’s ID card and starting the Pre-Certification process. For Inpatient services, the call should be made prior to Hospital Confinement. In the case of an emergency, the call should take place as soon as reasonably possible.

The following Inpatient and Outpatient services or supplies require Pre-Certification:
1. All Inpatient admissions, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of substance abuse, or a residential Treatment facility;
2. All Inpatient maternity care after the initial 48/96 hours;
3. All partial hospitalization in a Hospital, residential Treatment facility, or facility established primarily for the Treatment of substance abuse.

Pre-Certification is not required for a medical emergency or Urgent Care or Hospital Confinement for maternity care.

Pre-Certification is not a guarantee that Benefits will be paid.

The Insured Person’s Physician will be notified of Our decision as follows:
1. For elective (non-emergency) admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the number of Inpatient days, if any, approved;
2. For Confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact Us before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone.

Our agent will make this determination within seventy-two (72) hours for an urgent request and four (4) business days for non-urgent requests following receipt of all necessary information for review. Notice of an Adverse Determination made by Our agent will be in writing and will include:
1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.
3. Notice of the availability, upon request of the Insured Person, or the Insured Person’s designee, of the clinical review criteria relied upon to make the Adverse Determination. This notice will specify what, if any additional necessary information must be provided to, or obtained by, Our agent in order to render a decision on any requested appeal.

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

If the Insured Person has any questions about their Pre-Certification status, they should contact their Provider.

**Inpatient Benefits**

1. **Hospital Room and Board Expense**, including general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed.
2. **Intensive Care Unit**, including 24-hour nursing care. This benefit is NOT payable in addition to room and board charges incurred on the same date.
3. **Hospital Miscellaneous Expenses**, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
a. The cost for use of an operating room;
b. Prescribed medicines;
c. Laboratory tests;
d. Therapeutic services;
e. X-ray examinations;
f. Casts and temporary surgical appliances;
g. Oxygen, oxygen tent;
h. Blood and blood plasma; and
i. Miscellaneous supplies.

4. **Preadmission Testing** for routine tests performed as a preliminary to the Insured Person’s being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI’s, NMR’s, and blood chemistries.

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

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

7. **Registered Nurse’s Services**, when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit. Care provided in the Insured Person’s home is only a Covered Medical Expense when Medically Necessary, ordered by a Physician and performed by a certified home health agency.

8. **Physical Therapy while Confined** when prescribed by the attending Physician.

9. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for Custodial Care or residential care is not covered.

**Outpatient Benefits**

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

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

3. **Rehabilitative and Habilitative Therapy** when prescribed by the attending Physician, limited to one visit per day.
4. **Emergency Services Expenses** only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

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

6. **Second Opinion Benefit** for a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:
   a. If the Insured Person questions the reasonableness or necessity of recommended surgical procedures;
   b. If the Insured Person questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition;
   c. If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the insured requests an additional diagnosis;
   d. If the Treatment plan in progress is not improving the medical condition of the Insured Person within an appropriate period of time given the diagnosis and plan of care, and the insured requests a second opinion regarding the diagnosis or continuance of the Treatment;
   e. If the Insured Person has attempted to follow the plan of care or consulted with the initial Physician concerning serious concerns about the diagnosis or plan of care.

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

8. **Outpatient Facility Fee** when an Insured Person is treated for a Covered Sickness or Covered Injury in an appropriately licensed outpatient facility including an Ambulatory Surgical Center. Operating room fees for surgery are paid under the Outpatient Surgery Miscellaneous Benefit and not this benefit.

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

10. **CT Scan, MRI and/or PET Scans** for diagnostic services when prescribed by a Physician.

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

12. **Prescription Drugs** for medication for which a Physician’s written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made.

   a. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
      1. The drug is approved by the FDA;
      2. The drug is prescribed for the Treatment of a life-threatening condition, including cancer, HIV or AIDS;
      3. The drug has been recognized for Treatment of that condition by one of the following: a) The American Medical Association Drug Evaluations; b) The American Hospital Formulary Service Drug Information; c) The United States Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

As it pertains to this benefit, life-threatening means either or both of the following:
  a. Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
  b. Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

b. Investigational Drugs and Medical Devices – The Prescription Drug benefit includes a drug or device that is Investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

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

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

14. **Home Health Care Expense** for Home Health Care for an Insured Person when, otherwise, Hospitalization or Confinement in a Skilled Nursing Facility would have been necessary.

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

**Other Benefits**

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

2. **Allergy Injections/Treatment** includes Treatment of anaphylaxis and angioedema, severe chronic sinusitis not responsive to medications and asthma not responding to usual Treatments. This also includes the administration of allergy therapy, injections, allergy serum, and supplies used for allergy therapy.

3. **Ambulance Service** for transportation to or from a Hospital by a licensed Ambulance whether a ground or air Ambulance, in a Medical Emergency.

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

5. **Durable Medical Equipment** for the rental or purchase of Durable Medical Equipment, including, but not limited to, Hospital beds, wheel chairs, walkers, and Prosthetic Devices. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable Medical Equipment must:
   a. Be primarily and customarily used to serve a medical, Rehabilitative purpose;
b. Be able to withstand repeated use; and

c. Generally not be useful to a person in the absence of Injury or Sickness.

6. **Maternity Benefit** for maternity charges as follows:

   a. Routine prenatal care

   b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness.

      Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

   c. **Inpatient Physician charges or Surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

   d. **Physician-directed Follow-up Care** including:

      1) Physician assessment of the mother and newborn;
      2) Parent education;
      3) Assistance and training in breast or bottle feeding;
      4) Assessment of the home support system;
      5) Performance of any prescribed clinical tests; and
      6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

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

   e. **Outpatient Physician’s visits** will be covered the same as for any other Covered Sickness.

7. **Routine Newborn Care** - when expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person. We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:

   a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   
   b. Inpatient Physician visits for routine examinations and evaluations;
   
   c. Charges made by a Physician in connection with a circumcision;
   
   d. Routine laboratory tests;
   
   e. Postpartum home visits prescribed for a newborn;
   
   f. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and
   
   g. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the Treatment of such newly born child.

8. **Nutritional Counseling** for dietary counseling and Treatment for Insured Persons with an inherited metabolic disorder, such as PKU. This includes oral amino acid based elemental formulas.

9. **Consultant/Specialist Physician Services** when requested and approved by the attending Physician.

10. **Covered Clinical Trials** includes coverage for routine costs associated with an Insured Person’s participation in a clinical trial. Coverage does not include the studied device, equipment or drug, data collection services and any
11. **Accidental Injury Dental Treatment for Insured Persons** as the result of Injury. Routine dental care and Treatment are not payable under this benefit. Damage to the Insured Person’s teeth due to chewing or biting is not deemed an accidental Injury and is not covered.

12. **Sickness Dental Expense Benefit for Insured Persons over age 18** when, by reason of Sickness, an Insured Person requires Treatment for impacted wisdom teeth or dental abscesses, We will pay the Covered Percentage of the Covered Charges incurred for the Treatment.

13. **Non-emergency Care While Traveling Outside of the United States.**

14. **Medical Evacuation and Repatriation**
   The maximum combined benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits.

   **Medical Evacuation Expense** – If:
   a. An Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness;
   b. That occurs while he or she is covered under this Policy,
   We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or the Insured Person’s Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

   Payment of this benefit is subject to the following conditions:
   a. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a Confinement of five or more consecutive days immediately prior to medical evacuation;
   b. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;
   c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;
   d. No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person’s insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the Confinement ends or 31 days after the date of termination;
   e. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and
   f. Transportation must be by the most direct and economical route.

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

15. **Dental Care Benefit** for the following dental care services for Insured Persons.
   a. Emergency dental care, which includes emergency Treatment required to alleviate pain and suffering caused by dental disease or trauma.
   
   b. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
      1) Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
      2) Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
      3) Sealants on unrestored permanent molar teeth; and
      4) Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
   
   c. Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:
      1) Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
      2) X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month
intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
3) Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
4) In-office conscious sedation;
5) Amalgam, composite restorations and stainless steel crowns; and
6) Other restorative materials appropriate for children.

d. Endodontic services, including procedures for Treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

e. Prosthodontic services as follows:
   1) Removable complete or partial dentures, including six (6) months follow-up care; and
   2) Additional services include insertion of identification slips, repairs, relines and rebases and Treatment of cleft palate.

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

f. Orthodontics (child only coverage) used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

   Procedures include but are not limited to:
   1) Rapid Palatal Expansion (RPE);
   2) Placement of component parts (e.g. brackets, bands);
   3) Interceptive orthodontic Treatment;
   4) Comprehensive orthodontic Treatment (during which orthodontic appliances are placed for active Treatment and periodically adjusted);
   5) Removable appliance therapy; and
   6) Orthodontic retention (removal of appliances, construction and placement of retainers).

16. **Pediatric Vision Care Benefit** for Insured Persons who are age 18 and under

17. **Adult Vision Care** for Insured Persons over the age of 18.

18. **Chiropractic CareBenefit** for Treatment of a Covered Injury or Covered Sickness and performed by a Physician.

19. **Organ Transplant Surgery**
   **Recipient Surgery** for Medically Necessary, non-experimental and non-investigational solid organ, bone marrow, stem-cell or tissue transplants. We will provide benefits for the Hospital and medical expenses of the Insured Person who is the recipient of an Organ Transplant. This benefit does not cover routine harvesting and storage of stem cells from newborn cord blood, the purchase price of any organ or tissue.
   
   **Donor’s Surgery** for Medically Necessary transplant services required by the Insured Person when the Insured Person serves as an organ donor only if the recipient is also an Insurer Person. We will not Cover the transplant services of a non-Insured Person acting as a donor for an Insured Person if the non-Insured Person’s expenses will be Covered under another health plan or program.

   **Travel Expenses** when the facility performing the Medically Necessary transplant is located more than 200 miles from an Insured person’s residence, coverage will be provided for lodging, meals and transportation expenses limited
to a maximum of $2,000 per Policy Year or $250 per day, whichever is less while at the transplant facility.

Non-Covered Services for transportation and lodging include, but are not limited to:

a. Child care;

b. Mileage within the medical transplant facility city;

c. Rental cars, buses, taxis, or shuttle service, except as specifically approved by Us;

d. Frequent flyer miles;

e. Coupons, vouchers, or travel tickets;

f. Prepayments or deposits;

g. Services for a condition that is not directly related or a direct result of the transplant;

h. Telephone calls;

i. Laundry;

j. Postage;

k. Entertainment;

l. Interim visits to a medical care facility while waiting for the actual transplant procedure;

m. Travel expenses for donor companion/caregiver;

n. Return visits for the donor for a Treatment of condition found during the evaluation.

20. **Dialysis Care** for Medically Necessary Treatment of kidney disease or failure.

21. **Chemotherapy and Radiation Therapy** for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness, as shown in the Schedule of Benefits.

**Mandated Benefits for South Carolina**

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

**Autism Spectrum Disorder** for the Treatment of Autism Spectrum Disorder that is prescribed by the Insured Person’s treating Physician in accordance with a Treatment plan. To be eligible for coverage the Insured Person must be diagnosed with Autism Spectrum Disorder at age 8 or younger. Coverage for behavioral therapy is subject to a fifty-four thousand seven hundred dollars ($54,700) maximum per Policy Year.

As used in this benefit:
Autism Spectrum Disorder means one of the three following disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association: Autistic Disorder; Asperger’s Syndrome; and any pervasive developmental disorder – not otherwise specified.

**Cancer Diagnosis Coverage** for Mammograms, annual Pap Smears, and prostate cancer examinations, screenings, and laboratory work for diagnostic purposes in accordance with the most recent published guidelines of the American Cancer Society.

As used in this benefit:
Mammogram means a radiological examination of the breast for purposes of detecting breast cancer when performed as a result of a Physician referral or by a health testing service which utilizes radiological equipment approved by the Department of Health and Environmental Control, which examination may be made with the following minimum frequency:

a. Once as a base-line Mammogram for a female who is at least 35 years of age but less than 40 years of age;

b. Once every two years for a female who is at least 40 years of age but less than 50 years of age;

c. Once a year for a female who is at least 50 years of age; or

d. In accordance with the most recent published guidelines of the American Cancer Society.

Pap Smear means an examination of the tissues of the cervix of the uterus for the purpose of detecting cancer when performed upon the recommendation of a Physician, which examination may be made once a year or more often if recommended by a Physician.
Cleft Lip and Palate Coverage for the Medically Necessary care and Treatment of cleft lip and palate and any condition or illness which is related to or developed as a result of a cleft lip and palate. Care and Treatment will include, but is not limited to, these types of Medically Necessary care:

a. Oral and facial surgery, surgical management, and follow-up care made necessary because of cleft lip and palate;
b. Prosthetic Treatment such as obdurators, speech appliances, and feeding appliances;
c. Orthodontic Treatment and management;
d. Prosthodontic Treatment and management;
e. Otolaryngology Treatment and management;
f. Audiological assessment, Treatment, and management performed by or under the supervision of a Physician, including surgically implanted amplification devices; and
g. Physical Therapy assessment and Treatment.

Diabetes Coverage for the equipment, supplies, FDA-approved medication indicated for the Treatment of diabetes, and outpatient self-management training and education for the Treatment of Insured Persons with diabetes mellitus, if Medically Necessary, and prescribed by a health care professional who is legally authorized to prescribe such items and who demonstrates adherence to minimum standards of care for diabetes mellitus as adopted and published by the Diabetes Initiative of South Carolina.

Mastectomy Coverage for mastectomy surgery and for Prosthetic Devices and reconstruction of the breast on which surgery for breast cancer has been performed and surgery and reconstruction of the non-diseased breast, if determined Medically Necessary by the attending Physician with Our approval. We will also provide for the hospitalization for mastectomies for at least 48 hours following a mastectomy. Nothing in this benefit shall be construed to prohibit an attending Physician from releasing the Insured Person prior to the expiration of the time provided herein. In the case of an early release, coverage shall include at least one home care visit if ordered by the attending Physician.

SECTION VI - EXCLUSIONS AND LIMITATIONS

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

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

1. International Students Only - Eligible expenses within the Insured Person’s Home Country or country of origin that would be payable or medical Treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
2. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
3. professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
4. strained or flat feet, corns, calluses ingrown toenails or Treatment because of Injury, infection or disease.
5. diagnostic or surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
6. Treatment or removal of nonmalignant moles warts, boils, acne.
7. expenses covered under any Workers’ Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
8. charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
9. any expenses in excess of Usual and Reasonable charges except as provided in the policy.
10. loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
11. loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
12. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;
14. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
15. Services that are duplicated when provided by both a certified Nurse-midwife and a Physician.
16. Expenses payable under any prior Policy which was in force for the person making the claim.
17. Injury sustained as the result of the Insured Person’s operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
18. Expenses incurred after:
   a. The date insurance terminates as to the Insured Person; and
   b. The end of the Policy Year specified in the Benefit Schedule.
19. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
20. Charges incurred for acupuncture in any form, except to the extent provided in the Schedule of Benefits.
21. Expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.
22. Expenses for radial keratotomy, or hearing aids, except as required for repair caused by a Covered Injury or as provided under the Pediatric Vision Care Benefit.
23. Racing or speed contests, skin diving, or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV’s (all terrain or similar type vehicles) or other hazardous sport or hobby.
24. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical Treatment within 24 hours of the Accident or results from Reconstructive Surgery.
   o For the purposes of this provision, **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
   o For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient’s appearance or alter their personal concept of body image.
25. An Insured Person’s:
   o Committing or attempting to commit a felony,
   o Being engaged in an illegal occupation, or
   o Participation in a riot.
27. Custodial Care service and supplies.
28. Expenses that are not recommended and approved by a Physician.
29. Sexual reassignment surgery, except as provided when Medically Necessary or when Treatment is covered under the policy. This exclusion does not include related mental health counseling.
30. Cosmetic procedures related to Gender Dysphoria including but not limited to rhinoplasty, face lift, facial bone reduction, lip enhancement or reduction, blepharoplasty, breast augmentation, body contouring, reduction thyroid chondroplasty, hair removal, voice modification surgery, skin resurfacing, chin implants, nose implants.
31. Routine harvesting and storage of stem cells from newborn cord blood.
32. Under the Prescription Drug Benefit shown in the Schedule of Benefits, any drug or medicine:
   o Obtainable Over the Counter (OTC) unless Medically Necessary, except as specifically provided under Preventive Care;
   o For the Treatment of alopecia (hair loss) or hirsutism (hair removal);
   o For the purpose of weight control;
   o Anabolic steroids for body building;
   o Growth hormones;
   o Sexual enhancement drugs;
   o Cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or Treatment of acne;
   o Treatment of nail (toe or finger) fungus;
   o Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
   o For an amount that exceeds a 30 day supply;
o drugs labeled, “Caution – limited by federal law to Investigational use” or Experimental Drugs;
o purchased after coverage under the policy terminates;
o consumed or administered at the place where it is dispensed;
o if the FDA determines that the drug is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason.

33. non-chemical addictions.
34. non-physical, occupational, speech therapies (art, dance, etc.).
35. modifications made to dwellings.
36. general fitness, exercise programs.
37. vitamins, minerals, food supplements.
38. obesity Treatment.
39. hypnosis.
40. rolfing.
41. biofeedback.
42. hyperhidrosis.

**Third Party Refund - When:**

1. an Insured Person is injured through the negligent act or omission of another person (the "third party"); and
2. benefits are paid under the Policy as a result of that Injury.

We are entitled to a refund by the Insured Person of all Policy benefits paid as a result of the Injury.

The refund must be made to the extent that the Insured Person receives payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. The Insured Person must complete and return the required forms to Us upon request.

**COORDINATION OF THIS POLICY’S BENEFITS WITH OTHER BENEFITS**

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

**DEFINITIONS**

1. A Plan is any of the following that provides benefits or services for medical or dental care or Treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.
   a. Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.
   b. Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each Policy for coverage under a. or b. is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.
2. This plan means, in a COB provision, the part of the Policy providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Policy providing health care benefits is separate from this plan. A Policy may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

3. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

4. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, 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.

The following are examples of expenses that are not Allowable expenses:

a. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

b. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

c. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

d. If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangements 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 Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

e. 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, pre-certification of admissions, and preferred provider arrangements.

5. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

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

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is
primary.

(2) 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 Policy 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 Non-Preferred Provider benefits.

C. 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.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
      ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.
   However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
   b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
      ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
      iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         • The Plan covering the Custodial parent;
         • The Plan covering the spouse of the Custodial parent;
         • The Plan covering the non-custodial parent; and then
         • The Plan covering the spouse of the non-custodial parent.
   c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee,
member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its 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 any 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.

B. If an Insured Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Our Agent or We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Our Agent or We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Our Agent or We any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by Our Agent or We is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

SECTION VII - GENERAL POLICY PROVISIONS

Entire Contract. Changes: This Policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and
unless such approval be endorsed hereon. No agent has authority to change this Policy or waive any of its provisions.

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

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

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

Time of Payment: Indemnities payable under this Policy will be paid immediately upon receipt of due proof of such Loss.

Payment of Claims: Benefits will be paid to the Insured Person. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at Our option, be paid either to such beneficiary or to such estate.

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

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

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

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

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

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.

2. The Insured Person will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.

3. Our acknowledgment of the receipt of notice given under this Policy, or the furnishing of forms for filing proofs of
loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Policy.

4. This Policy is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium or comply with any of the provisions of this Policy when such failure is due to inadvertent error or clerical mistake.

7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Policy term and within one year after the termination of this Policy.

8. Benefits are payable under this Policy only for those expenses incurred while the Policy is in effect as to the Insured Person. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits.

SECTION IX – APPEALS PROCEDURE

For purposes of this Section, the following definitions apply:

**Adverse Determination** means a determination by Us or Our designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a Covered Medical Expense has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated. Denials of coverage based on a determination that a service recommended or requested health care or Treatment is Experimental also are Adverse Determination and must comply with procedures for reviewing coverage denials based on a determination that a recommended or requested health care service or Treatment is Experimental.

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

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

**Internal Review Procedure**

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

South Carolina Department of Insurance 1201 Main St. Suite 1000, Columbia, SC 29201

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

We will provide the Insured Person with the contact person who is coordinating the first level review within 3 days of the date of receipt of the grievance.
After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 30 days for a Prospective Review request or 60 days for a Retrospective Review request after receipt of the notice requesting the first level review.

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

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

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

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

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

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

In the event that the Insured Person disagrees with Our internal review determination, the Insured Person or his or her authorized representative may:

a. File a complaint with the South Carolina Department of Insurance 1201 Main St. Suite 1000, Columbia, SC 29201 (803) 737-6160 http://doi.sc.gov/; or

b. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

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

**External Review Procedure**

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an
Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

We shall notify the Insured Person in writing of the Insured Person's right to request an external review at the time the We send written notice of:

a. An Adverse Determination upon completion of the Our utilization review process described above; or

b. A final Adverse Determination.

A request for external review must be made within four months of receiving notice that an adverse determination has been made. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.

2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person.

3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.

4. We will review the request and if it is:

a. Complete we will initiate the external review and notify the Insured Person of:
   i. The name and contact information for the assigned independent review organization or the Commissioner of Insurance, as applicable for the purpose of submitting additional information; and
   ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn’t apply to expedited request or external reviews that involve an Experimental or Investigational Treatment.

b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.

5. We will not afford the Insured Person an external review if:

a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or

b. The Insured Person has failed to exhaust Our internal review process; or

c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

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

a. The reason for the denial; and

b. That the denial may be appealed to the Commissioner of Insurance.

6. For an expedited review: the Insured Person may make a request for an expedited external review after receiving an adverse benefit determination if:

a. The Insured’s treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time frame of an expedited internal review.

b. The Insured Person’s treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person, or would jeopardize the Insured Person’s ability to regain maximum function, if treated after the time frame of a standard external review.

c. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.

An Insured Person may pursue an Expedited External Review at the same time they are pursuing an Expedited Appeal.

7. An Insured Person shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by Us, the insurer.
8. At the request of the independent review organization, the Insured Person, provider, health care facility rendering health care services to the Insured Person, or Us shall provide any additional information the independent review organization requests to complete the review.

9. If the independent review organization does not receive any requested information necessary to complete the review they are not required to make a decision. They shall notify the Insured Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means.

10. We may elect to cover the service requested and terminate the review. We shall notify the Insured Person and all other parties involved with the decision by mail, or with the consent or approval of the Insured Person, by electronic means.

11. In the case of an expedited review, the independent review organization shall issue a written decision within seventy-two (72) hours after being assigned an expedited external review. In all other cases, written decision shall be issued no later than forty-five (45) days after the filing of the request for review to the Insured Person, the insurer and the Insured Person’s provider or the health care facility if they requested the review. The written decision shall include a description of the Insured Person’s condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

12. We shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the Insured Person’s policy or certificate.

External Review of Denial of Experimental or Investigative Treatment
Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination that involves a denial of coverage based on a determination that the health care service or Treatment recommended or requested is Experimental or Investigational, an Insured Person or the Insured Person's authorized representative may file a request for external review with the Commissioner of Insurance.

An Insured Person or the Insured Person's authorized representative may make an oral request for an external review of the Adverse Determination or final Adverse Determination if the Insured Person's treating Physician certifies, in writing, that the recommended or requested health care service or Treatment that is the subject of the request would be significantly less effective if not promptly initiated.

Upon receipt of a request for an expedited external review, the Commissioner of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Commissioner of Insurance immediately shall notify and send a copy of the request to Us. For an expedited external review request, at the time We receive the notice, We or Our designee utilization review organization shall provide or transmit all necessary documents and information considered in making the Adverse Determination or final Adverse Determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.
ATLANTA INTERNATIONAL INSURANCE COMPANY
Marine Air Terminal, LaGuardia Airport, Flushing, NY 20931

Amendment

Policyholder: Clemson University Policy Number: AIIC1718SCSHIP21

Effective Date: November 6, 2017

This Amendment form is made a part of the Policy and any Certificate to which it is attached as of the Effective Date shown above.

1. The “Schedule of Benefits” appearing in the Certificate is amended to add the following:

   **Referral Penalty:**
   If a student and Dependent spouse do not obtain a Referral, from the Student Health Center then: We will not pay for Covered Expenses under the plan.

2. The Student Health Referral section of the Certificate is deleted and replaced with the following:

   **STUDENT HEALTH CENTER REFERRAL**

Where available, the student and Dependent spouse must first use the resources of the Student Health Center (SHC) where Treatment will be administered or a referral issued that verifies that the services were not available at the SHC. You are then free to seek services outside the SHC. Expenses incurred for medical Treatment rendered outside of the SHC for which no prior approval or referral is obtained will be subject to the Referral Penalty shown on the Schedule of Benefits. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary **ONLY** under the following conditions:
1. For an Emergency Medical Condition. The student must return to the SHC for necessary follow-up care;
2. When the SHC is closed;
3. For medical care received when the student is more than 30 miles from campus;
4. For medical care obtained when a student is no longer able to use the SHC due to a change in student status.
5. For maternity care;
6. When service is rendered at another facility during break or vacation period;
7. Medical care is obtained by a student who is not eligible to use the SHC;
8. Mental Health Disorders.

A written referral from the SHC is recommended for any follow-up care, with a Provider other than the SHC, after Emergency services. An SHC referral does not constitute a guarantee of Benefits when Treatment is provided outside the SHC.

Dependent children are not eligible to use the SHC and are exempt from the above limitation and requirements.

3. The Adult Vision Care benefit appearing in the ‘Other Benefits” section of the Certificate is deleted and replaced with the following:

   Adult Vision Care for Insured Persons age 19 and over. We will provide benefits for one (1) routine eye examination every 12 months and 1 pair of prescribed lenses and frames or contact lenses in lieu of lenses and frames per policy year.
4. The Adult Vision Care benefit appearing in the “Schedule of Benefits” section of the Certificate is deleted and replaced with the following:

<table>
<thead>
<tr>
<th>Adult Vision Care</th>
<th>N/A</th>
<th>100% of Usual and Reasonable Charge for Covered Medical Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(age 19 and older)</td>
<td></td>
<td>Copayment: $20</td>
</tr>
<tr>
<td>Routine Eye Exam once every 12 months and 1 pair of prescribed lenses and frames or contact lenses in lieu of frames and lenses per Policy Year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5. The following are added to the “Other Benefits” section of the Certificate:

**Diagnostic Testing for Attention Deficit Disorders and Learning Disabilities Expense.** Includes Diagnostic testing for attention deficit disorder or attention deficit hyperactivity disorder.

**Tuberculosis (TB) screening, Titers, Quantiferon B tests including shots** (other than covered under Preventive Services) when required by the school for high risk Insured Persons.

**Wellness Services (not otherwise covered under Preventive Services).** Includes services that promote health and well-being not otherwise covered under this Certificate, but is not limited to, routine Physician’s visits, routine physical examinations, diagnostic tests and procedures, routine testing, screening, and services related to routine physical examinations.

6. The “Schedule of Benefits” appearing in the Certificate is amended to add the following:

<table>
<thead>
<tr>
<th>BENEFITS FOR COVERED INJURY/SICKNESS</th>
<th>STUDENT HEALTH CENTER</th>
<th>PREFERRED PROVIDER</th>
<th>NON-PREFERRED PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness Services (not otherwise covered under Preventive Services).</td>
<td>100% of Preferred Allowance for Covered Medical Expenses Deductible Waived</td>
<td>100% of Preferred Allowance for Covered Medical Expenses Deductible Waived</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses Deductible Waived</td>
</tr>
<tr>
<td>Tuberculosis(TB) screening, Titers, Quantiferon B tests including shots (other than covered under Preventive Services)</td>
<td>100% of Preferred Allowance for Covered Medical Expenses Deductible Waived</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses Deductible Waived</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses Deductible Waived</td>
</tr>
<tr>
<td>Sickness Dental Expense for Insured Person’s over age 18 Subject to $1,000 per tooth maximum per Policy Year</td>
<td>N/A</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing for Attention Disorders and Learning Disabilities Expense.</td>
<td>100% of Preferred Allowance for Covered Medical Expenses Deductible Waived</td>
<td>100% of Preferred Allowance for Covered Medical Expenses Deductible Waived</td>
<td>70% of Usual and Reasonable Charge for Covered Medical Expenses Deductible Waived</td>
</tr>
</tbody>
</table>

SC SHIP AMEND-1 (2017)
This Amendment ends at the same time as the Policy and Certificate. It is subject to all of the terms, limitations and conditions of the Policy and Certificate except as they are changed by it.

SIGNED FOR ATLANTA INTERNATIONAL INSURANCE COMPANY

[Signature]

Andrew M. DiGiorgio, President  Angela Adams, Secretary

Policyholder acceptance:

Policyholder: ________________________________  Date: ________________________________

SC SHIP AMEND-1 (2017)
HIPAA Notice of Privacy Practices of

ATLANTA INTERNATIONAL INSURANCE COMPANY

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

Effective: June 01, 2017

This Notice of Privacy Practices (“Notice”) applies to Atlanta International Insurance Company’s (“we”, “us” or “our”) insured health benefits plan. We are required to provide you with this Notice.

Personal Information is information that identifies you as an individual, such as your name and Social Security Number, as well as financial, health and other information about you that is nonpublic, and that we obtain so we can provide you with insurance coverage.

Protected Health Information (your “Health Information”) is information that identifies you as related to your physical or mental health, your health care, or payment for your healthcare.

Our Responsibilities
We are required by law to maintain the privacy of the Health Information we hold and to provide you with this Notice and to follow the duties and privacy practices described in this Notice. We are required to abide by the terms of this Notice currently in effect.

We utilize administrative, technical, and physical safeguards to protect your information against unauthorized access and against threats and hazards to its security and integrity. We comply with all applicable state and federal rules pertaining to the security and confidentiality of your information.

We will promptly inform you if a breach has occurred that may have compromised the privacy or security of your Health Information.

Overview of this Notice
This Notice describes how certain information about you may be used and disclosed and how you can get access to this information. This Notice addresses three primary areas:

• An overview of Your Health Information. This section addresses how we collect your information, how we use it to run our business, and the reasons we share it.
• Your Rights. This section gives an overview of the rights you have with respect to your information we have in our records.
• How to Contact Us. In case you have any questions, requests, or even if you feel you need to make a complaint, we want to make sure you are in contact with the right person.

YOUR HEALTH INFORMATION

How We Acquire Your Information
In order to provide you with insurance coverage, we need Personal Information about you. Some of this information is collected from the school during the enrollment period. Other information comes to us from your health care provider, other insurers, third party administrators (TPAs), and your school’s health center. This information is necessary to properly administer your health plan benefits.
How We use Your Health Information
Below are some examples of how we use and disclose your Health Information. Broadly, we will use and disclose your Health Information for Treatment, Payment and Health Care Operations.

Treatment refers to the health care treatment you receive. We do not provide treatment, but we may disclose certain information to doctors, dentists, pharmacies, hospitals, and other health care providers who will take care of you. For example, a doctor may send us information about your diagnosis and treatment so we can develop a health care plan and arrange additional services.

Payment refers to activities involving the collection of premiums, payment of claims, and determining covered services. For example, we may review your Health Information to determine if a particular treatment is medically necessary and what that payment for the services should be.

Health Care Operations refers to the business functions necessary for us to operate, such as audits, complaints responses and quality assurance activities. For example, we would use your Health Information (but not genetic information) for underwriting and calculating rates, or we may use your Health Information to detect and investigate fraud.

Additionally:
- We may confirm enrollment in this health plan with your school or to your school’s consultant or your school’s business partner.
- If you are a dependent of someone on the plan, we may disclose certain information to the plan’s subscriber, such as an explanation of benefits for a service you may have received.
- Your school’s health center may require enrollment information, payment information, or may require your Health Information to coordinate on-campus services you may need.

We may disclose your information when instructed to do so, including:
- Health oversight activities may require that we disclose your information to governmental, licensing, auditing and accrediting agencies;
- Legal proceedings may require disclosure of your Health Information in response to a court order or administrative order, or in response to a subpoena, discovery request, warrant, summons, or other valid process;
- Law enforcement activities might require disclosure of certain Health Information to local, state or federal law enforcement, so long as the release is authorized or required by law;
- As required by law or to avert a serious threat to safety or health; and,
- To certain government agencies, such as the Department of health and Human Services or the Office of Civil Rights if they are conducting an investigation or audit.

Authorizations
Occasionally we may receive a request to share your information in a manner outside of how we normally use your Health Information, as described above. In those cases, we will ask you for your authorization before we share your Health Information.

YOUR RIGHTS
You have the right to request restrictions on certain uses and disclosures of your Health Information, including the uses and disclosures listed in this Notice and disclosures permitted by law. You also have the right to request that we communicate with you in certain ways.
- We will accommodate reasonable requests;
- We are not required to agree to a request to restrict a disclosure unless you have paid for the cost of the health care item or service in full (i.e., the entire sum for the procedure performed) and disclosure is not otherwise required by law; and,
• If you are a minor, depending on the state you reside in, you may have the right in certain circumstances to block parental access to your Health Information. For example, a minor would have the rights of an adult with respect to diagnosis and care of conditions such as STDs, drug dependency, and pregnancy.

You have the **right to inspect and copy your Health Information** in our records. Please note that there are exceptions to this, such as:
• Psychotherapy notes;
• Information complied in reasonable anticipation, or for use in, a civil, criminal or administrative action or proceeding;
• Health Information that is subject to a law prohibiting access to that information; or,
• If the Health Information was obtained from someone other than us under a promise of confidentiality and the access request would be reasonably likely to reveal the source of the information.

We may deny your request to inspect and copy your Health Information if:
• A licensed health care professional has determined your requested access is reasonably likely to endanger your life or physical safety of another;
• The Health Information makes reference to another person and a licensed health care professional has determined that access requested is reasonably likely to cause substantial harm to another; or,
• A licensed health care professional has determined that access requested by your personal representative is likely to cause substantial harm to you or another person.

You have the **right to request an amendment** to your Health Information if you believe the information we have on file is incomplete or inaccurate. Your request must be in writing and must include the reason for the request. If we deny your request, you may file a written statement of disagreement.

You have the right to know who we have provided your information to - - this is known as an **accounting of disclosures**. A request for an accounting of disclosures must be submitted in writing to the address below. The accounting will not include disclosures made for treatment, payment, health care operations, for law enforcement purposes, or as otherwise permitted or required by law. If you request an accounting of disclosures more than once in a twelve (12) month period we may charge a reasonable fee to process, compile and deliver the information to you this second time.

You have a **right to receive a paper copy of this Notice**. Simply call the customer service line indicated on your ID card and request a paper copy be mailed to you. You may also submit a written request to us at the address below.

You will receive a notice of a breach of your Health Information. You have the **right to be notified of a breach** of unsecure Health Information.

Finally, you have the **right to file a complaint** if you feel your privacy rights were violated. You may also file a complaint with the Secretary of Health and Human Services.

**CONTACT**

For all inquiries, requests and complaints, please contact:

Privacy and Security Officer  
Atlanta International Insurance Company  
c/o Consolidated Health Plans  
2077 Roosevelt Avenue  
Springfield, MA 01104
This Notice is Subject to Change

We may change the terms of this notice and our privacy policies at any time. If we do, the new terms and policies will be effective for all of your Health Information we maintain, as well as any information we may receive or maintain in the future.

Please note that we do not destroy your Health Information when you terminate your coverage with us. It may be necessary to use and disclose this information for the purposes described above even after our coverage terminates, although policies and procedures will remain in place to protect against inappropriate use and disclosure.
Gramm-Leach-Bliley (“GLB”) Privacy Notice

We understand your privacy is important. We value our relationship with you and are committed to protecting the confidentiality of nonpublic personal information (“NPI”). This notice explains why we collect NPI, what we do with NPI and how we protect your privacy.

COLLECTING YOUR INFORMATION

We collect NPI about our customers to provide them with insurance products and services. This may include your name, Social Security number, telephone number, address, date of birth, gender, work/school enrollment history, and health history. We may receive NPI from your completing the following forms:

- Claims forms
- Enrollment forms
- Beneficiary designation/Assignment forms
- Any other forms necessary to effectuate coverage, administer coverage, or administer and pay your claims

We also collect information from others that is necessary for us to properly process a claim, underwrite coverage, or to otherwise complete a transaction requested by a customer, policyholder or contract holder.

SHARING YOUR INFORMATION

We share the types of NPI described above primarily with people who perform insurance, business and professional services for us, such as helping us pay claims and detect fraud. We may share NPI with medical providers for insurance and treatment purposes. We may share NPI with an insurance support or organization such as a policyholder’s or contract holder’s broker, a third-party administrator, reinsurer, employer, school, or plan sponsor. We may also share NPI when otherwise required or permitted by law, such as sharing with governmental or other legal authorities. When legally necessary, we ask your permission before sharing NPI about you. Our practices apply to our former, current and future customers.

We do not share your health NPI to market any product or service. We also do not share any NPI to market non-financial products and services.

When other companies help us conduct business, we expect them to follow applicable privacy laws. We do not authorize them to use or share NPI except when necessary to conduct the work they are performing for us or to meet regulatory or other governmental requirements.

HEALTH INFORMATION

We will not share any of your protected health information (“PHI”) unless allowed by law, and/or you have provided us with the appropriate authorization. Additional information on how we protect your PHI can be found in the Notice of Privacy Practices.

SAFEGUARDING YOUR INFORMATION

We have physical, electronic and procedural safeguards that protect the confidentiality and security of NPI. We give access only to employees or authorized individuals who need to know the NPI to provide insurance products or services to you. Our employees are continually trained on how to keep information safe.
ACCESSING YOUR INFORMATION

You may request access to certain NPI we collect to provide you with insurance products and services. You must make your request in writing and send it to the address below. The letter should include your full name, address, telephone number and policy number if we have issued a policy. If you request, we will send copies of the NPI to you. If the NPI includes health information, we may provide the health information to you through a health care provider you designate. We will also send you information related to disclosures. We may charge a reasonable fee to cover our processing costs.

This section applies to NPI we collect to provide you with coverage. It does not apply to NPI we collect in anticipation of a claim or civil or criminal proceeding.

CORRECTING YOUR INFORMATION

If you believe the NPI we have about you is incorrect, please write to us. Your letter should include your full name, address, telephone number and policy number if we have issued a policy. Your letter should also explain why you believe the NPI is inaccurate. If we agree with you, we will correct the NPI and notify you of the correction. We will also notify any person who may have received the incorrect NPI from us in the past two (2) years if you ask us to contact that person.

If we disagree with you, we will tell you we are not going to make the correction. We will give you the reason(s) for our refusal. We will also tell you that you may submit a statement to us. Your statement should include the NPI you believe is correct. It should also include the reason(s) why you disagree with our decision not to correct the NPI in our files. We will file your statement with the disputed NPI. We will include your statement any time we disclose the disputed NPI. We will also give the statement to any person designated by you if we may have disclosed the disputed NPI to that person in the past two (2) years.

CONTACTING US

If there are any questions concerning this notice, please feel free to write us at:

Privacy and Security Officer
Atlanta International Insurance Company
c/o Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
ADVISORY NOTICE TO POLICYHOLDERS

U.S. TREASURY DEPARTMENT’S OFFICE OF FOREIGN ASSETS CONTROL (“OFAC”)

No coverage is provided by this Policyholder Notice nor can it be construed to replace any provisions of your policy. You should read your policy and review your Declarations page for complete information on the coverages you are provided.

This Policyholder Notice provides information concerning possible impact on your insurance coverage due to the directives issued by OFAC and possibly by the U.S. Department of State. Please read this Policyholder Notice carefully.

OFAC of the U.S. Department of Treasury administers and enforces economic and trade sanctions policy on Presidential declarations of “National Emergency”. OFAC has identified and listed numerous:

- Foreign agents;
- Front organizations;
- Terrorists;
- Terrorist organizations; and
- Narcotics traffickers

as Specially Designated Nationals and Blocked Persons. This list can be found on the U.S. Department of Treasury’s website (www.treas.gov/ofac)

In accordance with OFAC regulations, or any applicable regulation promulgated by the U.S. Department of State, if it is determined that you or another insured, or any person or entity claiming the benefits of this insurance has violated U.S. sanctions law or is identified by OFAC as a Specially Designated National or Blocked Person, this insurance will be considered a blocked or frozen contract and all provisions of this insurance will be immediately subject to OFAC. When an insurance policy is considered to be such a blocked or frozen contract, neither payments nor premium refunds may be made without authorization from OFAC. Other limitations on the premiums and payments also apply.