PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

FLORIDA MEMORIAL UNIVERSITY STUDENT HEALTH DOMESTIC PLAN

EFFECTIVE AUGUST 1, 2017

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INTRODUCTION

This document is a description of Florida Memorial University Student Health Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for eligible Students and designated Dependents when the Student and such Dependents satisfy all eligibility requirements of the Plan.

The Plan Administrator fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Students and their Dependents and is divided into the following parts:

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.**

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Students. All Active Students.

Eligibility Requirements for Student Coverage. A person is eligible for Student coverage from the first day that he or she:

(1) is a Full-Time Undergraduate Students J-1 Visa Exchange Student and Scholar, Part-Time Student, or Graduate Student.

(2) Has submitted a completed application and payment

(3) Actively attends classes for the first 31 days once coverage is elected

(4) This plan document is effective September 1. Coverage for the Student begins on the first day the Student is housed on Campus.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Student's Spouse.

The term "Spouse" shall mean the person recognized as the covered Student's husband or wife under the laws of the state where the covered Student lives or was married, and shall not include common law marriages. The term "Spouse" shall include partners of the same sex who were legally married under the laws of the State in which they were married. The Plan Administrator may require documentation proving a legal marital relationship.

(2) A covered Student's Child(ren).

A Student's "Child" includes his natural child, stepchild, grandchild, adopted child, or a child placed with the Student for adoption. A Student's Child will be an eligible Dependent until reaching the limiting age of 26. When the child reaches the applicable limiting age, coverage will end on the child's birthday.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

(3) A covered Student's Qualified Dependents.

The term "Qualified Dependents" shall include children for whom the Student is a Legal Guardian and children, adopted children and children placed for adoption with the Student.

To be eligible for Dependent coverage under the Plan, a Qualified Dependent must be under the limiting age of 26 years. Coverage will end on the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

The Plan Administrator may require documentation proving eligibility for Dependent coverage, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

(4) A covered Dependent Child or Qualified Dependent who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Student for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals, continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Student's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Student; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Student.

If a person covered under this Plan changes status from Student to Dependent or Dependent to Student, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Students, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of a Student will become eligible for Dependent coverage on the first day that the Student is eligible for coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse, Qualified Dependent or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

Pre-Existing for International students. International Students are not subject to requirements set forth by the Affordable Care Act, so the plan utilizes a pre-existing condition exclusions under the following scenarios:

- No previous coverage or a gap in coverage of more than 65 days
- If any injury or sickness, or any complications there from which is present or manifest itself, or for which medical care, treatment, advice or consultation was rendered to a Covered Person with the 12 months period prior to the Effective Date of Coverage. Any injury or sickness shall be considered to be present or manifest if the condition or symptoms exist prior to the Effective Date of coverage, even though no diagnosis, care or treatment were sought or received.
    - These Injuries or sicknesses are not covered within the 6 month waiting period, unless the International student is able to provide proof of credible coverage for the prior 12 months without a break in coverage of no more than sixty-five (65) day
    - Services rendered at the student health center are not subject to the waiting period

FUNDING

Cost of the Plan. The level of any Student premiums is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Student premiums.

ENROLLMENT

Enrollment Requirements. A Student must enroll for coverage by filling out and signing an enrollment application along with the appropriate premium payment.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Student who has Dependent coverage is not automatically enrolled in this Plan. Charges for covered nursery care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the parents will be responsible for all costs.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child. If the newborn child is required to be enrolled and is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

Disclosure Requirements. Any person who, with intent to defraud or knowing that he is facilitating a fraud against the Plan, submits an application containing a false or deceptive statement is guilty of insurance fraud.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Students (husband and wife or Domestic Partners) are covered under the Plan and the Student who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Student as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period.

If an individual loses eligibility for coverage as a result of failure to enroll or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of enrollment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If a Student is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage. However, a request for enrollment must be made within 30 days after the coverage ends.

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Student Educational Benefit Trust, (877) 233-5159.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage creating a Special Enrollment right.** A Student or Dependent who is eligible, but not enrolled in this Plan, may enroll if loss of eligibility for coverage meets all of the following conditions:

(a) The Student or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Student stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) The coverage of the Student or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and the coverage was terminated as a result of loss of eligibility. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Student or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Student or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (i.e.: part-time employees).

(b) The Student or Dependent has a loss of eligibility as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Student or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Student or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Student or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) Dependent beneficiaries. If:

(a) The Student is a participant under this Plan (or is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Student through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Student) may be enrolled under this Plan. In the case of the birth or adoption of a child, the Spouse of the covered Student may be enrolled as a Dependent of the covered Student if the Spouse is otherwise eligible for coverage. If the Student is not enrolled at the time of the event, the Student must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Student must request enrollment during this 30-day period.

The coverage of the Dependent and/or Student enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Medicaid and State Child Health Insurance Programs.** A Student or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Student or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Student or Dependent is terminated due to loss of eligibility for such coverage, and the Student or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Student or Dependent becomes eligible for assistance with payment of Student contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Student or Dependent requests enrollment in this Plan within 60 days after the date the Student or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Student is not then enrolled, the Student must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following the date the completed enrollment form is received unless an earlier date is established by the Plan Administrator.

EFFECTIVE DATE

Effective Date of Student Coverage. A Student will be covered under this Plan as of the date that the Student satisfies all of the following and is housed on Campus, but no earlier than September 1:

(1) The Eligibility Requirement.

(2) The Active Student Requirement.

(3) The Enrollment Requirements of the Plan.

Active Student Requirement.

A Student must be an Active Student (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Student is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

The Plan has the right to rescind any coverage of the Student and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Plan Administrator or Plan may either void coverage for the Student and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action. The plan Administrator will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The plan Administrator reserves the right to collect additional monies if claims are paid in excess of the Student's and/or Dependent's paid contributions.

When Student Coverage Terminates. Student coverage will terminate on the earliest of these dates:

(1) The date the Plan is terminated.

(2) The date in which the covered Student ceases to be in one of the Eligible Classes. This includes death or termination of Active Enrollment of the covered Student.

(3) If a Student commits fraud, makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the plan Administrator or Plan may either void coverage for the Student and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

When Dependent Coverage Terminates. (Unless otherwise stated throughout the Summary Plan Description) A Dependent's coverage will terminate on the earliest of these dates:

(1) The date the Plan or Dependent coverage under the Plan is terminated.

(2) The date that the Student's coverage under the Plan terminates for any reason including death.

(3) The date a covered Spouse loses coverage due to loss of eligibility status.

(4) Coverage will end on the date in which the Qualified Dependent ceases to meet the applicable eligibility requirements.

(5) Coverage will end on the date in which the Child ceases to meet the applicable eligibility requirements.

(6) If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the plan Administrator or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

THE UNIVERSITY STUDENT HEALTH INSURANCE PLAN is designed to protect against unexpected medical expense and to meet most students' needs while on campus and throughout the Policy Year. Often a student covered by a Health Maintenance Organization (HMO) or a managed care policy at home, has limited or no benefits while at the University, in other parts of the U.S. or in a foreign country. When reviewing your current policy, check to ensure that it provides access to healthcare providers in the University area and provides comprehensive coverage, extending beyond emergency care to include hospitalization (including room and board, physicians' fees, and surgical expenses), lab tests, x-rays, prescription drugs, mental health care, and sports injuries.

If you have other coverage, your other plan is primary and your student health plan will pay on an excess basis.
Plan means a plan, which provides benefits or services for, or by reason of, medical, or dental care or treatment through:

(1) Group, blanket, franchise, or subscriber insurance coverage;

(2) Pre-paid plans for:
- (a) group hospital service;
- (b) group medical service;
- (c) group practice;
- (d) individual practice; and
- (e) any other such plans for members of a group;

(3) Any plan provided by:
- (a) labor management trusts;
- (b) unions;
- (c) employer organizations;
- (d) professional organization; or
- (e) employee benefit organizations;

(4) A government program or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;

(5) Any group or group type hospital indemnity of more than $100 per day;

(6) Medicare (Title XVII of the Social Security Act); and

(7) Any group, group-type and individual automobile “no fault” and traditional automobile “fault” type contracts.

SCHEDULE OF BENEFITS

Verification of Eligibility: Student Educational Benefit Trust (877) 233-5159

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Usual and Reasonable; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be precertified or reimbursement from the Plan may be reduced.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Hospitalizations
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care
Hospice Care
Durable Medical Equipment > $500
Physical and/or occupational therapy
Cardiac rehabilitation therapy
Outpatient surgical procedures (other than the physician's office)
Non-emergency MRI/CAT/MRA/PET scans
Observation > 23 hours
Chemotherapy / Radiation therapy
Organ transplants
Sleep Studies
Dialysis
Prosthetics

Please see the Cost Management section in this booklet for details.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive better benefits from the Plan than when a Non-Network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher In-Network payment will be made for certain Non-Network services: Usual and Customary applies

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within a 50 mile radius of the patient's residence.

If a Covered Person is in or out of the PPO service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives Physician, anesthesia or ancillary services by a Non-Network Provider at an In-Network facility.

Deductibles and certain Copayments are payable by Plan Participants.

Copayments and Deductibles are dollar amounts that the Covered Person must pay before the Plan pays. See the Schedule of Benefits for details.

A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan Year and it must be paid before any money is paid by the Plan for any Covered Charges. Each September 1st, a new deductible amount is required.

A copayment is the amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments. Copayments accrue toward the 100% maximum out-of-pocket payment.

Information and Records Disclaimer

At times the Plan may need additional information from the participants in order to furnish the Plan with all information and proofs that the Plan may reasonably require regarding any matters pertaining to the Policy. If the Participants do not provide this information when requested, it may delay or deny payment of their Benefits.

By accepting Benefits under this Plan, they authorize and direct any person or institution that has provided services to them to furnish the Plan with all information or copies of records relating to the services provided. The Plan has the right to request this information at any reasonable time. This applies to all Covered Participants, including Enrolled Dependents whether or not they have signed the Subscriber's enrollment form. The Plan agrees that such information and records will be considered confidential.

MEDICAL BENEFITS SCHEDULE

	GROUP SPECIFIC NETWORK	IN-NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM BENEFIT	UNLIMITED		
Note: The Network deductibles and out-of-pocket amounts ARE NOT applied to the Non-Network deductibles and out-of-pocket amounts. The Non-Network deductibles and out-of-pocket amounts ARE NOT applied to the Network deductibles and out-of-pocket amounts. Deductibles do not apply when a Copayment is required.			
DEDUCTIBLE, PER PLAN YEAR			
Per Covered Person	$0	$150	$500
OUT-OF-POCKET MAXIMUM, PER PLAN YEAR			
Individual/Family	$5,000/$10,000		$5,000/$10,000
STUDENT HEALTH CENTER			
Office visits	100%		
On-campus Mental Health visit	100%		
Prescriptions	$5/$15/$30		
Labs & X-rays, Tests & Procedures	100%	Paid based on where the specimen or x-ray was taken	
INPATIENT			
Inpatient Hospital Expenses (precertification required)	90% up to $1,200, then 60%	80% up to $1,200, then 60%	60% of usual and customary
Surgical Expenses, Anesthesia, Assistant Surgeon	90%	80%	60% of usual and customary
Intensive Care Unit (precertification required)	90% up to $1,200, then 60%	80% up to $1,200, then 60%	60% of usual and customary
Transplant Services (precertification required)	90%	80%	60% of usual and customary
Mental Health & Substance Abuse (precertification required)	90% up to $1,200, then 60%	80% up to $1,200, then 60%	60% of usual and customary
Rehabilitative and Habilitative Services (Physical, Speech, Occupational, and Cardiac Therapy, Chemotherapy, Radiation Therapy) (precertification required)	90%	80%	60% of usual and customary
Skilled Nursing (90 days plan year maximum)	90%	80%	60% of usual and customary
OUTPATIENT BENEFITS			
Surgical Expenses (precertification required)	90% up to $1,200, then 60%	80% up to $1,200, then 60%	60% of usual and customary
Primary Care Visit to treat an injury or illness	90%	80%	60% of usual and customary
Specialist Visit	90%	80%	60% of usual and customary

Other Practitioner Office Visit	90%	80%	60% of usual and customary
Emergency Medical Transportation	80% up to $750, then 60%	80% up to $750, then 60%	80% of usual and customary up to $750, then 60% of usual and customary

Urgent Care Facility	90%	80%	60% of usual and customary
Habilitative and Rehabilitative (Physical, Speech, Occupational, and Cardiac Therapy) (precertification required)	90% for visits 1-25, then 60%	80% for visits 1-25, then 60%	60% of usual and customary
	Visits 1-25 are combined for Tiers 1 & 2		
Chiropractic	90% for visits 1-25, then 60%	80% for visits 1-25, then 60%	60% of usual and customary
	Visits 1-25 are combined for Tiers 1 & 2		
Emergency use of the Emergency Room (non Medical Emergency not covered)	$250 copay	$250 copay, then 80%	$250 copay, then 80% of usual and customary
Laboratory & X-ray Expense	90%	80%	60% of usual and customary
Tests & Procedures	90%	80%	60% of usual and customary
Injections	90%	80%	60% of usual and customary
Mental Health & Substance Abuse	90%	80%	60% of usual and customary
MRI/CAT/MRA/PET scans (precertification required)	90%	80%	60% of usual and customary
Renal Dialysis (precertification required)	90%	80%	60% of usual and customary
PEDIATRIC VISION CARE			
Exam, including fitting and follow-up care for regular contact lenses	N/A	100% (one per year)	Up to $30 (one pair of glasses total per year)
Single Vision Lenses	N/A	100% (one pair of glasses total per year)	Up to $25 (one pair of glasses total per year)
Bifocal Lenses	N/A	100% (one pair of glasses total per year)	Up to $35 (one pair of glasses total per year)
Trifocal Lenses	N/A	100% (one pair of glasses total per year)	Up to $45 (one pair of glasses total per year)
Lenticular Lenses	N/A	100% (one pair of glasses total per year)	Up to $45 (one pair of glasses total per year)
Evaluation and fitting for specialty lenses (including, but not limited to, toric, multifocal, and gas permeable lenses)	N/A	Up to $60 (one per year)	Up to $60 (one per year)

Elective Contact Lenses	N/A	Up to $150 (in lieu of glasses)	Up to $75 (in lieu of glasses)
Medically Necessary Contact Lenses	N/A	Up to $600	Up to $225
Frames	N/A	Up to $150 (one pair of glasses total per year)	Up to $30 (one pair of glasses total per year)
PEDIATRIC DENTAL CARE			
Class A - Basic	100%	100%	90% of usual and customary
Class B - Intermediate	70%	70%	60% of usual and customary
Class C - Major	50%	50%	40% of usual and customary
Class D - Orthodontic	50%	50%	50% of usual and customary
ADDITIONAL BENEFITS			
Prenatal and Postnatal Care	90% (100% for Preventive services)	80%	60% of usual and customary
Durable Medical Equipment (precertification required if over $500)	80%	80%	80% of usual and customary
Home Health Care (precertification required)	90%	80%	60% of usual and customary
Hospice (precertification required)	90%	80%	60% of usual and customary
Treatment for TMJ	80%	80%	80% of usual and customary
Infertility (Counseling, Testing & Treatment)	80% up to $750, then 60%		
Transexualism/ Gender Identity	80% up to $750, then 60%		
Club Sports maximum of $500	90%	80%	60% of usual and customary
Intramural Sports maximum of $500	90%	80%	60% of usual and customary
ICS Sports maximum of $25000	100%	100%	60% of usual and customary

	GROUP SPECIFIC PROVIDERS	IN-NETWORK PROVIDERS	NON-NETWORK PROVIDERS
PREVENTIVE SERVICES & WELLNESS BENEFITS			
Adult Preventive Care/ Screening/ Immunization	100%	100%	60% of usual and customary

- Abdominal Aortic Aneurysm (Once per lifetime screening for men);
- Alcohol Misuse screening/counseling;
- Aspirin use for men and women of certain ages;
- Blood Pressure screening;
- Cholesterol screening for adults of certain ages or at higher risk;
- Colorectal Cancer screening for adults over 50;
- Depression screening;
- Type 2 Diabetes screening for adults with high blood pressure;
- Diet counseling for adults at higher risk for chronic disease;
- HIV screening for adults;
- Immunization vaccines: (Doses, ages, and recommended populations vary);
  - Hepatitis A;
  - Hepatitis B;
  - Herpes Zoster;
  - Human Papillomavirus;
  - Influenza;
  - Measles, Mumps, Rubella;
  - Meningococcal;
  - Pneumococcal;
  - Tetanus, Diphtheria, Pertussis;
  - Varicella;
  - Anthrax;
  - BCG (tuberculosis);
  - Japanese encephalitis;
  - Rabies;
  - Smallpox;
  - Typhoid;
  - Yellow fever
- Obesity screening and counseling;
- Sexually Transmitted Infection (STI) prevention counseling for higher risk;
- Tobacco Use counseling and interventions;
- High blood pressure screening;
- Syphilis screening for higher risk;
- Falls prevention in older adults;
- Hepatitis C virus infection screening: adults;
- Lung cancer screening;
- Hepatitis B screening;
- Skin cancer behavioral counseling.

Women's Preventive Care Services	100%	100%	60% of usual and customary

- Anemia screening on a routine basis for pregnant women
- Bacteriuria urinary tract or other infection screening for pregnant women
- BRCA counseling about genetic testing for women with higher risk
- Breast cancer Mammography screenings
- Breast cancer Chemoprevention counseling for women at higher risk
- Breast Feeding intervention to support and promote breast feeding
- Cervical cancer screening for sexually active women
- Chlamydia infection screening for younger women and other women at higher risk
- Folic Acid supplements for women who may become pregnant
- Gonorrhea screening for all women at higher risk
- Hepatitis B screening for pregnant women at their first prenatal visit
- Osteoporosis screening for women over age 640 depending on risk factors
- Rh Incompatibility screening for pregnant women & follow-up testing for women at higher risk
- Tobacco Use screening and interventions for all women, and expanded counseling
- Syphilis screening for all pregnant women or women at higher risk • Screening for gestational diabetes
- Human papillomavirus testing
- Counseling for sexually transmitted diseases
- Counseling for screening for human immune-deficiency virus
- FDA-approved female prescription contraceptive drugs and devices (e.g. diaphragm)
- FDA-approved female prescription contraceptive surgical procedures (e.g. IUD's)
- FDA-approved emergency contraceptive drugs
- Breastfeeding support, supplies and counseling
- Screening and counseling for interpersonal and domestic violence
- Preeclampsia prevention: aspirin;
- HIV counseling and screening;

Child and Adolescent Preventive Care/ Screening/ Immunization	100%	100%	60% of usual and customary

- Alcohol and Drug Use assessments for adolescents
- Autism screening for children at 18 and 24 months
- Behavioral assessments for children
- Cervical Dysplasia screening for sexually active females
- Congenital Hypothyroidism screening for newborns
- Developmental screening for children under age 3, and surveillance throughout childhood
- Dyslipidemia screening for children at higher risk for lipid disorders
- Fluoride Chemoprevention supplements for children without fluoride in their water source
- Gonorrhea preventive medication for the eyes of newborns
- Hearing screening for newborns
- Height, Weight and Body Mass Index measurements
- Hematocrit or Hemoglobin screening for children
- Hemoglobinopathis or sickle cell screening for newborns
- HIV screening for adolescents at higher risk
- Immunization vaccines: (Doses, ages, and recommended populations vary)
  - Diphtheria, Tetanus, Pertussis
  - Haemophilus influenzae type b
  - Hepatitis A
  - Hepatitis B
  - Human Papillomavirus
  - Inactivated Poliovirus
  - Influenza
  - Measles, Mumps, Rubella
  - Meningococcal
  - Pneumococcal
  - Rotavirus
  - Varicella
  - Anthrax;
  - BCG (tuberculosis);
  - Japanese encephalitis;
  - Rabies;
  - Smallpox;
  - Typhoid;
  - Yellow fever;
- Iron supplements for children ages 6 to 12 months at risk for anemia
- Lead screening for children at risk of exposure
- Medical History for all children throughout development
- Obesity screening and counseling
- Oral Health risk assessment for young children
- Phenylketonuria (PKU) screening for this genetic disorder in newborns
- Sexually Transmitted Infection (STI) prevention counseling for adolescents at higher risk
- Tuberculin testing for children at higher risk of tuberculosis
- Visual acuity screening between ages 3 and 5;
- Dental caries prevention: infants and children up to age five years;
- Depression screening: adolescents;
- Hepatitis B screening: adolescents;
- Tobacco use interventions;
- Skin cancer behavioral counseling.

INTERCOLLEGIATE SPORTS BENEFIT RIDER	
BENEFIT PERIOD:	Provided treatment begins within 90 days from the date of Injury, Benefits are payable for 104-weeks from the date of an Injury. The Injury must occur after the effective date and prior to the termination date and care must be Medically Necessary.
MAXIMUM BENEFIT AMOUNT	**$25,000** per benefit year
Benefits provided only for the following sport(s): Baseball, men's and women's basketball, men's and women's cross country, field hockey, football, men's and women's golf, men's and women's lacrosse, women's rowing, men's and women's soccer, men's and women's swim/dive, men's and women's tennis, men's and women's track and field, women's volleyball, men's and women's water polo, wrestling, intercollegiate cheerleading, student managers and student trainers.	
MEDICAL EXPENSE BENEFIT	100% of usual and customary after deductible

PRESCRIPTION DRUG BENEFIT SCHEDULE

	STUDENT HEALTH CENTER	WELLDYNE NETWORK PROVIDERS	NON-NETWORK PROVIDERS
RETAIL 30-DAY SUPPLY			
Tier 1 – Generic Drugs	$5 copayment	$5 copayment + 20%	$5 copayment + 40%
Tier 2 – Preferred Drugs	$15 copayment	$15 copayment + 20%	$15 copayment + 40%
Tier 3 – Non-Formulary Drugs	$30 copayment	$30 copayment + 20%	$30 copayment + 40%
Contraceptive	100%	100%	100%
MAIL ORDER 90-DAY SUPPLY			
Tier 1 – Generic Drugs	N/A	$12.50 copayment + 20%	$12.50 copayment + 40%
Tier 2 – Preferred Drugs	N/A	$37.50 copayment + 20%	$37.50 copayment + 40%
Tier 3 – Non-Formulary Drugs	N/A	$75 copayment + 20%	$75 copayment + 40%

Quality of Care. The Plan includes services to improve quality of patient care, including improving health outcomes by using a case management review, works with patients to reduce hospital readmissions, with resources to provide patient education, coordinating discharge planning, and recommending post-discharge follow-up care with the treating physician. Plan contracts with health care providers which are required to follow best clinical practices, and promote wellness and health improvement activities.

Summary of Benefits and Coverage. Each Covered Person will have access through the website for a summary of benefits and coverage, and printed copies are available upon request.

Clinical Trials. The Plan will not deny an individual with cancer or other life threatening diseases or conditions from participation in the clinical trial, will cover routine costs for items and services furnished in connection with such person's participation and will not discriminate on the basis of the individual's participation. The Plan, however, does not cover investigational items, devices or services, or adverse conditions caused by participation in such clinical trials.

Mental Health Parity and Addiction Equity. The Plan will cover inpatient psychotherapy subject to demonstration of medical necessity at 90% for in-network facilities regardless of length of stay. Non-network facilities are not approved for coverage unless there is no in-network facility available and only upon prior approval. Outpatient psychotherapy visits subject to medical necessity will be covered at 90% for in-network services providers.

Actuarial Value. The Plan ensures that coverage share of the total allowed cost of benefits provided is not less than 60% of such costs.

Renewability. Plan will discontinue or decline to renew individual coverage only based upon non-payment of premiums, fraud, violation, failing to meet the eligibility requirements, Plan ceasing to offer market coverage, or the Participant moving outside the service area. The Plan Sponsor reserves the right to discontinue to offer this or any plan or making changes to the Plan on a non-discriminatory basis.

Reducing Costs of Health Care Coverage. If, after the conclusion of the policy year, the ratio of the amount of premium expended on total costs to operate the Plan to the total premium revenue for the plan year is less than 80%, then each Covered Person will be eligible for a pro rata rebate of the actual amounts paid by such Covered Person.

ACCIDENTAL DEATH & DISMEMBERMENT

Loss of Life	100% up to $10,000
Loss of One Hand by Severance at or above the Wrist	50% up to $10,000
Loss of One Foot by Severance at or above the Ankle	50% up to $10,000
Entire and Irrecoverable Loss of Sight in One Eye	50% up to $10,000
Loss of more than one of the above in one Accident	100% up to $10,000

LIMITATIONS

(1) Illness, or medical or surgical treatment thereof, including diagnosis;

(2) Bacterial infection, except septic infection of and through a wound accidentally sustained;

(3) War or any act of war, whether war is declared or not; participation in a riot or insurrection of any kind;

(4) Injury sustained while in any of the armed forces (land, sea or air) of any country or international authority;

(5) Intentional self-inflicted injury or attempted suicide;

(6) The Covered Person being intoxicated or under the influence of any narcotic, unless administered on the advice of a Physician (whether a person is under the influence will be determined on the basis of the laws of the location where the injury occurred);

(7) The Covered Person committing or attempting to commit a felony or being in an illegal occupation;

(8) Injuries received while operating, learning to operate or acting as a pilot or crew member of an aircraft.

DEFINITIONS

(1) **Beneficiary** means the person or persons named in writing by the Covered Person to receive the benefits if the Covered Person dies.

(2) **Dependent** means:

(a) The lawful spouse of the Covered Person; or

(b) Any unmarried child who is at least 15 days, but less than 26 years old.

The term child means a child born of the Covered Person, a child legally adopted by the Covered Person, or a stepchild of the Covered person living with the Covered Person.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Plan Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan. The Plan Administrator maintains the discretion and authority to audit claims, or facilitate the auditing of claims, in order to fulfill its obligations as Plan Fiduciary, and to determine the amounts properly payable under this Plan as to all claims.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges incurred by a Covered Person during the Plan Year. The Maximum Benefit applies to all plans and benefit options offered under the Student Health Plan, including the ones described in this document.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for any charges excluded as shown in the Schedule of Benefits) for the rest of the Calendar Year.

COVERED CHARGES

Covered Charges are the Usual and Reasonable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) **Accidental Death & Dismemberment**. For loss of life, limb or sight, if such an Injury shall independently of all other causes and within 180 days from the date of Injury solely result in any one of the following specific losses, the Covered Person or beneficiary may request the Plan Administrator to pay the applicable amount according to the Plan specific benefit, in lieu of payment under the Medical Benefits.

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

(2) **Hospital Care.** The medical services and supplies furnished by a Hospital or Outpatient Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid at the facility's average private room rate.

Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

(3) **Coverage of Pregnancy.** The Usual and Reasonable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

Health plans generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

(4) **Physician Care.** The professional services of a Physician for surgical or medical services including home visits and online consultations/telemedicine.

Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

(a) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Usual and Reasonable Charge that is allowed for the primary procedures; 50% of the Usual and Reasonable Charge will be allowed for each additional procedure performed through the same or separate incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(b) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Usual and Reasonable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Usual and Reasonable percentage allowed for that procedure; and

(c) If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Usual and Reasonable allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

(a) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature.

(b) **Inpatient Nursing Care.** Inpatient private duty nursing care is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for private duty nursing nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.

(b) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(c) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(d) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(e) **Clinical trials** as a result of:

(i) Treatment provided for a life-threatening condition; or

(ii) Prevention, early detection, and treatment studies on cancer.

These benefits will be provided only if:

(i) The treatment is being provide or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer or for any other life-threatening condition;

(ii) The treatment is being provided in a clinical trial approved by:

a. One of the National Institutes of Health (NHI);
b. An NIH cooperative group or an NIH center;
c. The FDA in the form of an investigational new drug application;
d. The federal Department of Veterans Affairs; or
e. An institutional review board of an institution on the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NIH.

(iii) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;

(iv) There is no clearly superior, non-investigational treatment alternative and

(v) The available clinical or pre-clinical data provides a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

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

Patient cost does not include:

(i) The cost of an investigational drug or device;

(ii) The cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purpose of the clinical trial;

(iii) Costs associated with managing the research associated with the clinical trial; or

(iv) Costs that are not covered under this Plan for non-investigational treatments.

(f) Treatment of **diabetes** including all equipment, supplies, outpatient self-management training and educational services, and medical nutrition therapy, when the Covered Person's treating Physician or a Physician who specializes in the treatment of diabetes, or other appropriate licensed health care provider certifies that such services are for the treatment of:

(i) Insulin dependent diabetes;

(ii) Non-insulin dependent diabetes; or

(iii) Elevated blood glucose levels induced by Pregnancy.

(g) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase. Repairs may be considered if deemed Medically Necessary, if repairs do not exceed the fair market replacement value of the equipment at the time of repair. There is no coverage for repairs required due to mistreatment or misuse of equipment.

(h) **Laboratory studies.** Covered Charges for diagnostic and preventive lab testing and services. These include allergy tests.

(i) Treatment of **Mental Disorders and Substance Abuse**. Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:

All treatment is subject to the benefit payment limits shown in the Schedule of Benefits.

Physician's visits are limited to one treatment per day.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(j) Injury to or care of **mouth, teeth and gums**. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(k) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(l) The initial purchase, fitting and repair of **orthotic appliances** such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

(m) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(n) **Prescription** Drugs (as defined).

(o) Routine **Preventive Care.** Covered Charges under Medical Benefits are payable for routine Preventive Care as described in the Schedule of Benefits. Additional preventive care shall be provided as required by applicable law if provided by a Panel/Network/Participating Provider. A current listing of required preventive care can be accessed at www.HealthCare.gov/center/regulations/prevention.html.

Charges for Routine Well Adult Care. Routine well adult care is care by a Physician that is not for an Injury or Sickness.

Charges for Routine Well Child Care. Routine well child care is routine care by a Physician that is not for an Injury or Sickness.

(p) The initial purchase, fitting and repair of fitted **prosthetic devices** which replace body parts, and replacement if there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(q) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,in a manner determined in consultation with the attending Physician and the patient.

(r) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(s) Other **Therapies**

i. Pulmonary Rehabilitation
ii. Infusion Therapy
iii. Inhalation Therapy

(t) Charges associated with the initial purchase of a **wig after chemotherapy**.

(u) Diagnostic **x-rays**.

(v) Charges associated with care and treatment for **sterilization**.

(w) Coverage for **vision services** includes:

(1) Determination of refraction
(2) Routine ophthalmological examination including refractions for new and established patients
(3) A visual functional screening for visual acuity.

(x) Diagnostic **x-rays**.

(y) Clinical Trials

(1) The individual is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening disease or condition.
(2) Either—
(A) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
(B) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1)."

(z) Care and treatment for **Congenital Conditions**:

(1) Hemangiomas and port wine stains of the head and neck area
(2) Limb deformities such as club hand, club foot, syndactyly (webbed digits), polydactyly; (supernumerary digits), and macrodactylia
(3) Tongue release for diagnosis of tongue-tied;
(4) Otoplasty when performed to improve hearing by directing sound in the ear canal.
(5) Necessary care and treatment of medically diagnosed congenital birth defects and birth abnormalities of a Newborn or Adopted Infant;
(6) Treatment of Cleft Lip and Cleft Palate;
(7) Amino Acid-Based Elemental Formula;
(8) Medical Foods and Modified Food Products.

(aa) Pediatric Dental Care Services

(1) Class A Basic

Diagnostic and Treatment Services
Preventative Services
Palliative treatment of dental pain – minor procedure

(2) Class B Intermediate

Minor Restorative Services
Endodontic Services
Periodontal Services
Prosthodontic Services
Oral Surgery

(3) Class C Major

Major Restorative Services
Endodontic Services
Periodontal Services
Prosthodontic Services

(4) Class D Orthodontic

Orthodontia Services – Dependent Child Age Limit is 19

A complete list of specific procedure coverages and exclusions can be accessed at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-codes/2014/brochures/MetLife.pdf.

(bb) Pediatric Vision Care Services

Includes eye exams once a year, including dilation and routine ophthalmologic exam with refraction; glass or plastic lenses once a year, including single, bifocal, trifocal, lenticular lens powers, fashion and gradient tinting, oversized glass-grey #3 prescription sunglass lenses; polycarbonate prescription lenses with scratch resistance coating; frames for glasses; contact lenses in lieu of glasses; medically necessary contact lenses for Keratoconus, Pathological Myopia, Aphakia, Anisometropia, Aniseikonia, Aniridia, Corneal Disorders, Post-traumatic Disorders, and Irregular Astigmatism; and, low vision items.

COST MANAGEMENT SERVICES

Cost Management Services Phone Number

Student Educational Benefit Trust (877) 233-5159

The provider, patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 3 business days in advance of services being rendered or within 1 business day after a Medical Emergency.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:

Hospitalizations
Inpatient Substance Abuse/Mental Disorder treatments
Skilled Nursing Facility stays
Home Health Care
Hospice Care
Durable Medical Equipment > $500
Physical and/or occupational therapy
Cardiac rehabilitation therapy
Outpatient surgical procedures (other than the physician's office)
MRI/CAT/MRA/PET scans
Observation > 23 hours
Chemotherapy / Radiation therapy
Organ transplants
Sleep Studies
Dialysis
Prosthetics

(b) Retrospective review of the Medical Necessity of the listed services provided on an emergency basis;

(c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and

(d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from, or on behalf of, the Covered Person. Contact American Health Holding **at 800-641-5566 at least 3 business days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Student
- The name, Student identification number and address of the covered Student
- The name of the Plan Administrator: Florida Memorial University
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The proposed medical services
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact **American Health Holding at 800-641-5566 within 1 business day** after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced to the Non-Network benefit level coverage.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

SECOND AND/OR THIRD OPINION PROGRAM

Certain surgical procedures are performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition.

In order to prevent unnecessary or potentially harmful surgical treatments, the second and/or third opinion program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature. Benefits for the second (and third, if necessary) opinion will be paid as any other Sickness.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any surgical treatment is allowed a second opinion, the following procedures are ones for which surgery is often performed when other treatments are available.

Appendectomy	Hernia surgery	Spinal surgery
Cataract surgery	Hysterectomy	Surgery to knee, shoulder, elbow or toe
Cholecystectomy (gall bladder removal)	Mastectomy surgery	Tonsillectomy and adenoidectomy
Deviated septum (nose surgery)	Prostate surgery	Tympanotomy (inner ear)
Hemorrhoidectomy	Salpingo-oophorectomy (removal of tubes/ovaries)	Varicose vein ligation

PREADMISSION TESTING SERVICE

The Medical Benefits percentage payable will be for diagnostic lab tests and x-ray exams when:

(1) performed on an outpatient basis within seven days before a Hospital confinement;

(2) related to the condition which causes the confinement; and

(3) performed in place of tests while Hospital confined.

Covered Charges for this testing will be payable as stated in the Schedule of Benefits, even if tests show the condition requires medical treatment prior to Hospital confinement or the Hospital confinement is not required.

CASE MANAGEMENT

Case Management. The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

-- personal support to the patient;

-- contacting the family to offer assistance and support;

-- monitoring Hospital or Skilled Nursing Facility;

-- determining alternative care options; and

-- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan. Unless specifically provided to the contrary in the Plan Administrator's instructions, reimbursement for expenses incurred in connection with the treatment plan shall be subject to all Plan limits and cost sharing provisions.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Accident is an occurrence which is unforeseen, not due to or contributed to by Sickness or disease of any kind, and causes Injury.

Active Student is a Student who meets the eligibility requirements.

Ambulance is a licensed motor vehicle or rotary aircraft operated by licensed and certified personnel and used to provide transportation and life support services.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Ancillary services are services incurred while receiving services at an ambulatory surgery center, hospital or other inpatient health program. These may include x-ray interpretation, pathology, assistant surgeon, emergency room physician, anesthesia services, or inpatient physician visits from the network facility's staff.

Brand Name means a trade name medication.

Coinsurance is a policy provision under which the insurer and the insured share costs incurred after the deductible is met, according to a specific formula.

Cosmetic means to improve appearance or self-perception.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is a Student or Dependent who is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare or public health plans.

Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Creditable Coverage does not include coverage that was in place before a significant break of coverage of 63 days or more. With respect to the Trade Act of 2002, when determining whether a significant break in coverage has occurred, the period between the trade related coverage loss and the start of the special second COBRA election period under the Trade Act, does not count.

Custodial Care is care (including Room and Board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Dominant Commercial Payor is the most significant commercial payor by dollar volume at medical provider and/or payor with most favored nation clause in payor/provider agreement.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Emergency Services means a medical screening examination (as required under Section 1867 of the Social Security Act (EMTALA)) within the capability of the Hospital emergency department, including routine ancillary services, to evaluate a Medical Emergency and such further medical examination and treatment as are within the capabilities of the staff and facilities of the Hospital and required under EMTALA to stabilize the patient.

Student means a person who is an Active, Enrolled Student of Florida Memorial University.

Enrolled Student is a Student who meets the eligibility requirements.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ESRD means End Stage Renal (kidney) Disease.

Essential Health Benefits include, to the extent they are covered under the Plan, ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Student and the family members who are covered as Dependents under the Plan.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health

care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular

rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition manifesting itself by acute symptoms of sufficient severity including severe pain such that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in (1) serious jeopardy to the health of an individual (or, in the case of a pregnant woman, the health of the woman or her unborn child), (2) serious impairment to body functions, or (3) serious dysfunction of any body organ or part. A Medical Emergency includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medical Non-Emergency Care means care which can safely and adequately be provided other than in a Hospital.

Medically Necessary care and treatment is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

Never Event is a serious reportable adverse event that is reasonably preventable through application of evidence based guidelines. These errors include, but are not limited to the following: Surgery on wrong body part, foreign object left in patient after surgery, intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to facility.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotic is a mechanical device applied externally to limit or assist the motion of any given body part.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Outpatient Surgical Center, or the patient's home.

Personal Health Information includes medical information (i.e. claims, health assessments, etc.) and other administrative data (i.e. names, addresses, social security numbers, etc) that are personally identifiable.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means Florida Memorial University Student Health Plan, which is a benefits plan for certain Students and is described in this document.

Plan Participant is any Student or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Preventive Services means those services aimed at prevention, early detection, and early treatment of health conditions. This includes but is not limited to routine physical examinations, routine gynecological services, immunizations, preventive diagnostic screenings, and well person care.

Prosthetic Device means a device that replaces all or part of an internal body organ or external body member, or that replaces all or a part of the function of a permanently inoperative or malfunctioning internal body organ or external body member.

Semi-Private Room means a room containing two (2) or more patient beds in an inpatient facility.

Sickness is:

For a covered Student and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness disease, or Pregnancy.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

Total Disability (Totally Disabled) means: In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Urgent Care is medical care for an unexpected illness or injury that does not require emergency services but which may need prompt medical attention to minimize severity and prevent complications.

Usual and Customary (Reasonable) Charge (UCR): The usual fee charged in a geographic area by a medical provider for a specific medical procedure or service. The fee is based upon a consensus of what other medical providers in the same geographic area are accepting as payment for similar procedures or service.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary (Reasonable) Charge, even if the Provider is in Network.

The Plan Reimbursement to a Medical Provider is, regardless of PPO Agreement, limited to the Reasonable Reimbursement for the treating Medical Provider. We define Reasonable Reimbursement to the dominant Commercial Payor Reimbursement at the treating Medical Provider.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Customary.

PLAN EXCLUSIONS

Note: Any treatment, charges, and/or medical provider reimbursement not covered by Reinsurance contract.

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

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(1) Acupuncture. Services, supplies, care or treatment in connection with acupuncture.

(2) Adverse audit. Any amount determined by audit to not be payable.

(3) After hour services. Additional charges, billed by the physician, for after hour, extended hour, or holiday services.

(4) Air Ambulance. Charges for air transport services.

(5)

Alcohol. Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion applies to the perpetrator of an act of domestic violence but does not apply to the victim if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(6) Behavioral. Milieu therapy, learning disabilities, behavioral problems, parent-child problems, conceptual handicap, developmental delay or disorder or mental retardation; except as specifically provided in the benefit for Habilitative Services; or in the Benefits for treatment of ADHD, Mental Illness, Emotional Disorders, and Drug and Alcohol Abuse.

(7) Biofeedback. Services, supplies, care or treatment in connection with biofeedback.

(8) Chelation. Any charges for services, supplies, care or treatment related to chelation (metallic ion) therapy, unless due to heavy metal poisoning.

(9) Circumcision. Expenses incurred for circumcision, except for newborn infants.

(10) Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan, except complications from an abortion for a covered Student or Spouse.

(11) Cosmetic. Services, supplies, care or treatment, which is cosmetic in nature, except charges to correct congenital defects; to repair the effects of an injury; or reconstructive breast surgery performed on an individual; in the case of a double mastectomy and /or reconstruction, at least one of the breasts must have a current malignancy, verifiable family history, and surgery must be at the recommendation of the treating physician.

(12) Counseling. Any charges for marriage, relationship, group, pastoral or financial counseling.

(13) Court ordered. Any charges incurred as the result of court ordered treatment or testing.

(14) Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(15) Dental services. Dental Services, dental appliances or treatment including hospitalization for dental service except as specifically mentioned in Covered Medical Expenses. Facility charges for dental services due to age or mental capacity are not covered.

(16) Developmental delay. Rehabilitation services, including but not limited to physical therapy, occupational therapy, or speech therapy for developmental delay.

(17) Educational or vocational testing. Services for educational or vocational testing or training. This does not apply to any diabetic education that may be covered under the Plan.

(18) Elective treatment. Expenses incurred for elective treatment or elective surgery except as specifically provided elsewhere in the plan and performed while the plan is in effect.

(19) Electro-shock therapy. Charges in connection with electro-shock therapy.

(20) Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

(21) Exercise programs. Health spa or similar facilities, strengthening programs, or exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(22) Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary. This exclusion does not apply to coverage of routine patient care costs for qualified individuals participating in approved clinical trials.

(23) Eye care. Radial keratotomy, lasik surgery or other eye surgery to correct vision problems that are alternately correctable by vision lenses. Also, lenses for the eyes. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(24) Family planning. Expenses incurred for family planning and premarital examinations except as specifically provided in the Plan.

(25) Field training. Expenses for treatment of covered students who specialize in the mental health care field, and who receive treatment as part of their training in that field.

(26) Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia, plantar fasciitis, or bunions, except open cutting operations. Treatment or removal of corns or calluses; trimming, cutting, clipping, or debridement of toenails; any other hygienic or preventative care, unless required for treatment of metabolic or peripheral vascular disease.

(27) Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(28) Genetic testing. Any charges for genetic testing, except for any testing involving fetal demise; genetic markers for breast or ovarian cancer and testing on bone marrow material or lymph nodes for hematologic diseases; chorionic villus sampling (CVS) and amniocentesis for prenatal diagnosis of fetal chromosomal abnormalities if one of the following conditions is met: if the woman will be age 35 or older at the time of delivery; if she has had a previous child with a birth defect; if the parents' family histories indicate an increased risk of inheriting a genetic disorder.

(29) Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(30) Hair loss. Care and treatment for hair loss including wigs, wig maintenance, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy as listed in the Schedule of Benefits.

(31) Hazardous hobby or activity. Care and treatment of an Injury or Sickness that results from

engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an unusual activity, which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are, but not limited to, skydiving, auto racing, hang gliding, jet ski operating, snowmobiling, scuba diving, mountain climbing, cave exploration or bungee jumping.

(32) Hearing aids and exams. Charges for services or supplies in connection with hearing aids or exams for their fitting. This exclusion does not apply to hearing aids for minor Dependents.

(33) Hirsutism. Expenses incurred for hirsutism.

(34) Hospital employees. Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(35) Hypnosis. Charges in connection with hypnosis.

(36) Illegal acts. Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion applies to the perpetrator of an act of domestic violence but does not apply to the victims if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(37) Illegal drugs or medications. Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(38) Impotence. Care, treatment, services, supplies in connection with treatment for impotence.

(39) Incremental nursing. Any charges for incremental nursing.

(40) Intercollegiate sports. Expenses incurred for the treatment of accidents or injuries resulting from the participation in interscholastic, intercollegiate, or professional sport, contest or competition; traveling to or from such sport, contest or competition as a participant; or while participating in any practice or conditioning program for such sport, contest, or competition unless otherwise covered under the Plan specific benefits.

(41) Late submission. Charges for care, treatment, services or supplies which were incurred more than 12 months prior to the date the charges were submitted to the Plan for payment.

(42) Learning disabilities. Expenses incurred for learning disabilities except for disorders of Attention Deficit Disorder.

(43) Long-term/custodial nursing home care.

(44) Maintenance therapy. Treatment given when no additional progress is apparent, or expected to occur. Maintenance therapy includes treatment that preserves your present level of functioning and prevents loss of that functioning but which does not result in any additional improvement to the condition.

(45) Mammoplasty. Expenses incurred for breast reduction/mammoplasty.

(46) Massotherapy. Any charges for massotherapy**.**

(47) Medical non-emergency. Emergency room treatment of non-emergency conditions which are not a Medical Emergency in nature.

(48) Mental deficiency. Charges for care, treatment, services or supplies for mental deficiency, mental retardation and behavioral disorders, except Attention Deficit Hyperactivity Disorder. (Except for prescription drugs to age 15. Please also refer to the Prescription Drug limitations section)

(49) Miscellaneous charges. Charges for completion of claim forms or any charges associated with missed appointments.

(50) Morbid obesity. Care and treatment of morbid obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness.

(51) Motor vehicle injury. Charges incurred for the care or treatment of any injury sustained as a result of or related to any motor vehicle accident to the extent that such care or treatment for that injury is covered by any plan, program, policy or other arrangement providing insurance coverage for vehicles. Injury resulting from motor vehicle accident if the Covered person is not properly licensed to operate the motor vehicle in the jurisdiction in which the accident takes place (except in a Driver's Education program).

(52) Never event. Care, treatment, services, or supplies for Never Events- any adverse event that is reasonably preventable, is potentially excluded from coverage under the Plan. Possible non-reimbursement from the Plan includes, but is not limited to the following errors: Surgery on wrong body part, foreign object left in patient after surgery, intravascular air embolism, blood incompatibility, stage 3 or 4 pressure ulcers, electric shock, burn, or fall while confined to facility.**No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(54) Non-chemical addiction. Nicotine addiction, except as specifically provided in the benefits for Nicotine Replacement Therapy Drugs; caffeine addiction; non-chemical addiction to: gambling, sexual, spending, shopping, working and religious; codependency; except as specifically provided in the Benefits for treatment of Mental Illness, Emotional Disorders, and Drug and Alcohol Abuse.

(55) Non-compliance. All charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice.

(56) Non-emergency Hospital admissions. Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(57) No obligation to pay. Charges incurred for which the Plan has no legal obligation to pay

(58) No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(59) Not specified as covered. Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(60) Nutritional supplements. Charges for nutritional supplies or supplements, vitamins/mineral supplements.

(61) Obesity. Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness, unless such care is specifically covered in the Schedule of Benefits or required by applicable law. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals.

(62) Occupational. Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(63) Personal comfort items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood

pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(64) Plan design excludes. Charges excluded by the Plan design as mentioned in this document.

(65) Podiatric orthotics. Over the counter or custom made shoe inserts or foot orthotics to control foot function.

(66) Psychological testing. Charges for psychological testing for learning disabilities except Attention Deficit Disorder, or for the purpose of obtaining or maintaining employment.

(67) Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(68) Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

(69) Residential care. Charges for residential care day care for mental nervous, substance and/or alcohol abuse.

(70) Routine care. Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventative medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.

(71) Safety devices. For drivers and all passengers: charges for the treatment for injuries incurred when not wearing appropriate safety restraints and/or motorcycle helmets, when applicable.

(72) School fee for services. Expenses incurred for services normally provided without charge by the school and covered by the school fee for services.

(73) Screening exams. Any charges for the services, supplies, care or treatment for screening exams, including but not limited to, bone and body scanning.

(74) Self-inflicted. Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply to the victim if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition. This exclusion does apply to the perpetrator of an act of domestic violence.

(75) Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was Covered under this Plan or after coverage ceased under this Plan.

(76) Sex changes. Care, services or treatment for gender identity disorders or sex change surgery, except as specifically provided in the Plan.

(77) Sex therapy. Charges for sex therapy or treatment.

(78) Sinus surgery. Expenses incurred for sinus surgery, submucous resection and/or surgical correction for deviated septum, except for treatment of acute purulen sinusitis.

(79) Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

(80) Socialized medicine program. Expenses incurred by a Covered Person who is not a United States Citizen for services performed within the Covered Person’s home country if the Covered Person’s home country has a socialized medicine program (or provides national health).

(81) Structural change. Charges for structural changes to a house or vehicle.

(82) Subrogation. Charges for illnesses or injuries suffered by a covered person due to the action or

inaction of any party if the covered person fails to provide information as requested by the Claims Administrator.

(83) Substance abuse. Services, supplies, care or treatment to a covered person for injury or sickness resulting from voluntary taking of or being under the influence of legal or illegal substance, drug, hallucinogen or narcotic not administered on the advice of a physician.

(84) Supplies. Charges for supplies except as specifically provided in the Plan.

(85) Surrogate. Any services, supplies, care or treatment for a person in connection with a surrogate pregnancy.

(86) Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(87) Vision therapy. Charges in connection with vision therapy.

(88) War. Any loss that is due to a declared or undeclared act of war, civil insurrection or act of terrorism.

(89) Weekend admission. Charges relating to services or supplies provided during the Friday, Saturday and Sunday coincident with an admission beginning on any of those days, unless the admission is due to an accident or medical emergency, or surgery is scheduled for the day of or the day following the admission.

(90) Weight loss/gain. Services, supplies, care or treatment in connection with weight loss or weight gain, except charges for thyroid testing to determine if weight loss or gain is caused by a thyroid condition.

PRESCRIPTION DRUG BENEFITS

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. **Copayments**

The copayment is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits. The copayment amount is not a Covered Charge under the medical Plan. Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the amounts shown in the schedule of benefits will be the ingredient cost and dispensing fee.

Percentages Payable

The percentage payable amount is applied to each covered pharmacy drug or mail order drug charge and is shown in the schedule of benefits.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

Covered Prescription Drugs

(1) All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes contraceptives, but excludes any drugs stated as not covered under this Plan.

(2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.

(3) Insulin when prescribed by a Physician.

(4) Injectable drugs or any prescription directing administration by injection if medically necessary.

Limits To This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician.

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) **Administration.** Any charge for the administration of a covered Prescription Drug.

(2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

(3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

(4) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

(5) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids, Retin A or medications for hair growth or removal.

(6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person. This exclusion does not apply to coverage of routine patient care costs for qualified individuals participating in approved clinical trials.

(7) **FDA.** Any drug not approved by the Food and Drug Administration. This does not include any drug otherwise covered as a preventive service.

(8) **Growth hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance, unless medically necessary.

(9) **Immunization.** Immunization agents or biological sera.

(10) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

(11) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational".

(12) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.

(13) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(14) **Off Label use.** A charge for off label use of drugs except as prohibited by law or as approved by Plan.

(15) **Non-legend drugs.** A charge for any medication that can be purchased over-the-counter. This does not include any drug otherwise covered as a preventive service.

(17) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin. This does not include any drug otherwise covered as a preventive service.

(18) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

Note: Exclusions related to prescription drugs may not be limited to this list.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain a Claim form from the Student Educational Benefit Trust or the Plan Administrator.

(2) Complete the Student portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) Have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Student ID number
- Student's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at this address:

Continential Benefits
P.O. Box 3610
Brandon,FL 33509-3610

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 180 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

CLAIMS APPEALS PROCEDURE

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination."

Both the Claims and the Appeal procedures are intended to provide a full and fair review.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

Internal Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant has 6 months following receipt of the notification in which to file a written request for an Appeal of the decision.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

(1) was relied upon in making the benefit determination;

(2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse benefit Determination on Appeal within 60 days after receipt of the notice of Appeal.

External Appeals

If the Covered Person is not satisfied with the Internal Appeals determination, an External Appeal for an Adverse benefit Determination may be requested. You may request an external review if you or your provider disagrees with SEBT' decision. An external review by an Independent Review Organization/External Review Organization (ERO) made up of physicians or other appropriate health care providers. The ERO must have expertise in the problem or question involved.

To request an external review, the following requirements must be met:

(1) You have received notice of the denial of the claim.

(2) Your claim was denied because it was determined that the care was not necessary or was experimental or investigational.

(3) You have exhausted the applicable internal appeal processes or you qualify for a faster review.

The claim denial letter you receive from SEBT will describe the process to follow if you wish to pursue an external review, including a copy of the Request for External Review Form.

You must submit the Request for External Review Form to SEBT within 4 months after you received the final claim denial letter. You also must include a copy of the final claim denial letter and all other pertinent information that supports your request.

For more information about the External Review process, call the Member Services telephone number shown on your ID card.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Covered Person.

If a Covered Person is eligible for benefits under this Plan, and another plan(s), but does not make claims for benefits payable under another plan(s) the benefits payable under this Plan will be reduced to the extent of benefits that would have been payable under another plan had claims been made thereof. This reduction is regardless of coordination payment order.

When an individual is covered under this plan as a Student or as a Dependent, the Plan will reimburse treatment for End Stage Renal Disease (ESRD) for the initial 30 months at a rate not to exceed 135% of the Medicare allowable for incurred expenses.

THE UNIVERSITY STUDENT HEALTH INSURANCE PLAN is designed to protect against unexpected medical expense and to meet most students' needs while on campus and throughout the Policy Year. Often a student covered by a Health Maintenance Organization (HMO) or a managed care policy at home, has limited or no benefits while at the University, in other parts of the U.S. or in a foreign country. When reviewing your current policy, check to ensure that it provides access to healthcare providers in the University area and provides comprehensive coverage, extending beyond emergency care to include hospitalization (including room and board, physicians' fees, surgical expenses), lab tests, x-rays, prescription drugs, mental health care, and sports injuries.

If you are covered under another health insurance plan as well, your other plan will be primary and your student health plan will pay on an excess basis.
Plan means a plan, which provides benefits or services for, or by reason of, medical, or dental care or treatment through:

(1) Group, blanket, franchise, or subscriber insurance coverage;

(2) Pre-paid plans for:
- (a) group hospital service;
- (b) group medical service;
- (c) group practice;
- (d) individual practice; and
- (e) any other such plans for members of a group;

(3) Any plan provided by:
- (a) labor management trusts;
- (b) unions;
- (c) employer organizations;
- (d) professional organization; or
- (e) employee benefit organizations;

(4) A government program or statute, other than a state medical assistance plan that implements Title XIX of the Social Security Act of 1965;

(5) Any group or group type hospital indemnity of more than $100 per day;

(6) Medicare (Title XVII of the Social Security Act); and

(7) Any group, group-type and individual automobile "no fault" and traditional automobile "fault" type contracts.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

Excess Provision. No benefit under this Plan is payable for any expense incurred for Injury or Sickness which is paid or payable by other valid and collectible insurance or under an automobile insurance policy. Covered medical expenses exclude amounts not covered by the primary insurer due to penalties imposed on the Covered person for not complying with plan provisions or requirements.

End Stage Renal Disease. If a participating Student or Dependent becomes eligible for other coverage on the basis of end-stage renal (kidney) disease (ESRD), then the Plan will be the primary payor for the applicable coordination period as it is then defined under federal law (currently thirty (30) months for individuals who become eligible due to ESRD on or after October 31, 1997). After the expiration of the coordination period, the Plan will become secondary.

Under no circumstance will Payment by the Plan exceed 135% of the allowable for expenses incurred due to ESRD.

Claims determination period. Benefits will be coordinated on a Plan Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

The Plan may request or provide information from another insurer or any other organization or person for purposes of determining allowable charges. This information may be provided or obtained without consent or notice to any other person. This Plan will not pay claims that appear to be the liability of another plan or person

without having all documentation and guarantee of Plan Rights to Recovery formally agreed to by the Plan Participant and /or Legal Representative.

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Covered Person may incur medical or dental charges due to Injuries which may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to Recover payments from any Third Party or insurer. This Subrogation right allows the Plan to pursue any claim which the Covered Person has against any Third Party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Covered Person under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Covered Person as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Covered Person, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Covered Person to the payments of those benefits.

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Covered Person" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injury or Sickness, whether or not said losses reflect medical or dental charges covered by the Plan. "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means repayment to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue and place a lien upon the Covered Person's claims for medical or dental charges against the other person.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Covered Person is covered. This right of Refund also applies when a Covered Person Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Florida Memorial University Student Health Plan is the benefit plan of Florida Memorial University, the Plan Administrator, also called the Plan Sponsor. An individual or committee may be appointed by Florida Memorial University to be Plan Administrator and serve at the convenience of the Plan. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Florida Memorial University shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator maintains the discretion and authority to audit claims, or facilitate the auditing of claims, to determine if those claims are properly payable under the terms of the Plan. The decision of the Plan Administrator as to whether a claim is properly payable based upon an audit shall also be final and binding upon all persons dealing with the Trust or Plan or claiming any benefit thereto.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a Claims Administrator to pay claims.

(7) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

CLAIMS ADMINISTRATOR IS NOT A FIDUCIARY. A Claims Administrator is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

COMPLIANCE WITH HIPAA PRIVACY STANDARDS. Certain members of the Plan's administration perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these administrators from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these administrators are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Plan's administration unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or

mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Plan's administration shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. Genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Administrators.** The Plan shall disclose Protected Health Information only to members of the Plan's administration who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Plan's administration" shall refer to all students and other persons under the control of the plan Administrator.

(a) **Updates Required.** The Plan Administrator shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Plan's administration who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Plan's administration uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Plan Administrator.** The Plan Administrator must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Administrator with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or benefit plan of the Plan Administrator;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Administrator still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Plan's administration, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of Florida Memorial University's administration are designated as authorized to receive Protected Health Information from Florida Memorial University Student Health Plan ("the Plan") in order to perform their duties with respect to the Plan:

- Director of Business Planning
- Director of Risk Management
- Bursar Services Manager
- Assistant Athletic Directors
- Athletic Trainers
- Medical Director of Student Health Center
- Associate Staff Physician
- Staff Physician
- Nurse Practitioner
- Staff Nurse
- Medical Assistant
- Administrative Assistant
- Receptionist
- Student Liaison
- Plan Administrator of University

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Plan Administrator agrees to the following:

(1) The Plan Administrator agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic

Protected Health Information that the Plan Administrator creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Plan Administrator shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Plan Administrator shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Plan administrators and (4) Certification of Plan Administrator described above.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Student and Dependent Coverage:

The level of Student premiums will be set by the Plan Administrator. These premiums will be used in funding the cost of the Plan as soon as practicable after they have been received from the Plan Administrator.

Benefits are paid directly from the Plan through the Claims Administrator.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.