



Student Accident and Sickness Insurance Plan

designed for

Wesleyan University 2011-2012

Middletown, CT

Limited benefits health insurance disclosure statement. This student accident and sickness plan meets the state of Connecticut's minimum standards for major medical expense coverage.

UH B63003 0711-CT Policy Number - CUH201887

This limited health benefits plan does not provide comprehensive medical coverage. It is a basic or limited benefits policy and is not intended to cover all medical expenses. This plan is not designed to cover the costs of serious or chronic illness. It contains specific dollar limits that will be paid for medical services which may not be exceeded. If the cost of services exceeds those limits, the beneficiary and not the insurer is responsible for payment of the excess amounts. The specific dollar limits are as follows:

MAXIMUM BENEFIT: \$50,000 PER ACCIDENT OR SICKNESS.

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Student Eligibility and Enrollment Requirements

All undergraduate students at Wesleyan University must show proof of health insurance annually or enroll in the university-sponsored plan. Failure to show proof (waive) coverage by the deadline will result in a hold placed on class registration. Graduate students may enroll in the Student Accident and Sickness Insurance Plan on a voluntary basis. Students who pay tuition in the Fall 2011 and enroll in the plan will be insured from August 12, 2011 through August 12, 2012. Students who pay tuition for the Spring Semester of 2012 and enroll in the plan will be insured from January 15, 2012 through August 12, 2012.

Alternative Coverage

If you do not meet the Eligibility requirements of the Plan, you are not eligible for the Student Accident and Sickness Insurance Plan. Please contact Gallagher Koster, at 1-800-499-5062 for information on alternative plan options.

Dependent Eligibility and Enrollment Requirements

Eligible students may enroll their eligible Dependents, as defined the Definitions Section of this plan (see Page 2). Students must purchase coverage for their Dependent(s) at the same time of their initial plan enrollment and must purchase the same period of coverage as the student's period of coverage and cannot exceed coverage purchased by the student. For example, a student enrolled for annual coverage cannot purchase dependent coverage for the spring semester unless that student meets one of the late enrollee criteria for Dependents, as defined below. The Dependent Enrollment Form must also be received by the published deadline. An Eligible Student may add his or her Dependent as a late enrollee:

(a) When he or she marries. The application for coverage must be submitted within 31 days of the date of marriage. Coverage will be effective on the date of the marriage. Payment for the full semester is required even if the spouse is enrolled after the term has begun;

(b) When he or she provides a signed affidavit of civil union partnership. Proof of civil union partnership may be required. Payment for the full semester is required even if the civil union partner is enrolled after the term has begun;

(c) When he or she acquires a Dependent child through birth, adoption or guardianship decree. The application must be submitted within 31 days of the date the child is born, adopted or acquired through decree. Coverage will be effective as of the date of birth, adoption or guardianship. Payment for the full semester is required even if the Dependent child is enrolled after the term has begun; and

(d) When his or her Dependent arrives from a foreign homeland. The application for coverage must be submitted within 31 days of the date of the Dependent's arrival from the foreign homeland. Coverage will be effective as of the date of the Dependent's arrival following direct travel from the homeland. Payment for the full semester or pro-rated premium is required even if the Dependent is enrolled after the term has begun.

If dependent enrollment meets one of the specified late enrollee criteria, the Dependent Enrollment form, supporting documentation, and payment must be received by Gallagher Koster within 31 days of the qualifying event. If not received within 31 days of the qualifying event, the effective date of coverage will be the date this form and payment are received at Gallagher Koster. Once a Dependent is enrolled, coverage cannot be terminated unless the student loses eligibility.

The processes for online enrollment of Dependents are as follows:

Undergraduate Dependent Enrollment Process

Dependent Enrollment for the Annual or Spring term can be completed online through www.gallagherkoster.com/wesleyan. Click on Dependent Enroll.

Graduate Dependent Enrollment Process

Dependent Enrollment for the Annual or Spring term can be completed online through www.gallagherkoster.com/wesleyan. Click on the 'Waive/ Enroll' tab, then click the blue "I Want to Waive/Enroll" button and complete the dependent section of the enrollment form.

Policy Term

The insurance under Wesleyan University's Student Accident and Sickness Insurance Plan for the Annual Policy is effective at 12:01 a.m. on August 12, 2011. An eligible student's coverage becomes effective on that date. The Annual Policy terminates at 12:01 a.m. on August 12, 2012. The insurance for Spring Semester is effective at 12:01 a.m. on January 15, 2012 and terminates at 12:01 a.m. on August 12, 2012.

Premium Refund Policy

If an Insured Student withdraws from the university within the first 31 days of the first semester, and has not yet submitted a claim, he or she will receive a full refund of the insurance premium. If an Insured Student withdraws from the university after 31 days of the first semester, his or her coverage will remain in effect until the end of the term for which he or she was charged premium. If the Insured Student withdraws: (a) other than due to entering any military service; and (b) after the first 31 days of the semester, no premium refund will be made. Those Insured Students withdrawing from school to enter military service will be entitled to a pro-rata refund of premium upon written request of the withdrawal from school, and coverage will end as of the date of such entry.

The Insured Person may cancel their coverage within 31 days of the Effective Date of coverage by submitting a request for cancellation in writing to the university. Under no circumstances will a cancellation refund be provided if the Insured Person has filed a claim with Us.

Plan Cost

| | Annual Coverage 8/12/11 - 8/12/12 | Spring Semester 1/15/12 - 8/12/12 |
|--------------|---|---|
| Student Only | \$ 860.00 | \$ 601.00 |
| Spouse | \$2,262.00 | \$1,536.00 |
| Child(ren) | \$ 947.00 | \$ 637.00 |

Online Enrollment and Waiver Process (Undergraduates and Graduates)

Recognizing that health insurance coverage may change, at the beginning of each academic year, Undergraduate and Graduate students will be asked to notify the University of their Insurance Selection. To document proof of comparable coverage or to enroll in the Wesleyan University Student Accident and Sickness Plan, students need to complete the OnLine Decision Form and submit it by the deadline.

To enroll or waive:

1. Go to www.gallagherkoster.com/wesleyan.
2. Click on Student Waive/Enroll.
3. First Time Users of the website are required to create a unique User Account.
4. Once logged in, students should select the blue "I want to enroll/waive Undergraduate" or "I want to enroll/waive - Graduate" button. If waiving the insurance, have your current health insurance ID card ready. You will need this information in order to complete the waiver portion of the form.

Immediately upon submitting the Online Decision Form, you will receive a confirmation number that the Form was successfully submitted. Please print this confirmation number for your records.

If you do not receive a confirmation number, you will need to correct any errors and resubmit the form. The online process is the only accepted process for waiving or enrolling coverage.

Wesleyan University reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Wesleyan University Accident and Sickness Plan effective the date that the determination was made and there will be no pro-rata of premium.

Waiver Deadline

The deadline for Undergraduate and Graduate students to complete the Online Waiver Form for Annual coverage is August 15, 2011 and the deadline for students newly enrolled for the Spring Semester is January 30, 2012. Students who waive the Student Accident and Sickness Insurance Plan in the Fall waive coverage for the entire policy year.

Undergraduate students who do not submit the Online Enrollment or Waiver Form by the deadline will be automatically enrolled in the Student Accident and Sickness Insurance Plan and the fee will remain on their student account bill.

In the event that you waive the Student Accident and Sickness Insurance Plan and then lose your current coverage due to a qualifying event, i.e. your parent loses coverage or you reach the maximum limit available under a parent's plan, you have the right to petition to add coverage within 31 days of the qualifying event. If the petition is received within 31 days of the qualifying event, there will be no break in coverage. For petitions received after 31 days, the effective date of coverage will be the date that the petition is received at Gallagher Koster. If the petition is approved, the premium will not be prorated. To obtain a Petition to Add form visit www.gallagherkoster.com/wesleyan. Click on the Petition To Add tab.

Wesleyan University Student Health Services

Wesleyan University's Davison Health Center is located at 327 High Street, between Malcolm X House and the Davison Arts Center and is staffed by physicians, nurse practitioners, a physician associate, and nursing personnel who provide comprehensive primary care services for illness or injury to students. The staff provides an array of clinical and health education services, including assessment and treatment of illnesses and injuries, health, wellness, disease prevention counseling, nutritional counseling, international travel counseling, immunizations, allergy injections, HIV testing and counseling, and referral to outside specialists. The Health Center provides basic laboratory testing and a dispensary for many prescription and over-the-counter medications.

The Davison Health Center is open six days a week when classes are in session. An on call physician is available when the Health Center is closed and when classes are in session.

Optional Preferred Providers Provision

This Plan is an Indemnity Insurance Plan. While you may utilize any provider you choose, you will decrease your out-of-pocket expenses if you receive care locally and nationally through the First Health Network. Use of this Network of Providers is strictly optional.

To determine if a provider participates in the First Health network, students can call First Health toll-free at 1-888-685-7774 or visit www.Firsthealth.com. It is important that Insured Students verify that his or her Doctors are Network Providers when calling for an appointment or at the time of service.

Definitions

Accident means a specific unforeseen, unintended and unexpected event, which happens while the Insured Person is covered under this

Policy and which directly, and from no other cause results in an Injury.

Coinsurance means the percentage of Reasonable and Customary Expenses for which the Insured Person is responsible for a covered service.

Copayment means the specified dollar amount an Insured Person must pay for specified charges. The copayment is separate from and not a part of the Deductible or Coinsurance.

Covered Charge or Expense as used herein means those charges for any treatment, services or supplies that are: (a) not in excess of the Reasonable and Customary Expenses; (b) not in excess the charges that would have been made in the absence of this insurance; and (c) for Covered Charges requiring a Co-payment, an Insured Person will not be required to pay the amount in excess of Reasonable and Customary.

For purposes of the Accident Expense Benefit, charges for treatment, services or supplies incurred after coverage for an Insured Person has terminated will also be considered a "Covered Charge" or "Expense" provided such charges are directly related to an Accident incurred and within 52 weeks of the date of the Accident, provided the Accident occurred while coverage as to the injured person under this Policy is in force.

For purposes of the Sickness Expense Benefit, charges for treatment, services or supplies incurred after coverage for an Insured Person has terminated will also be considered a "Covered Charge" or "Expense" provided such charges are directly related to a Sickness incurred and within 52 weeks from the date of the first medical treatment for the named Sickness, provided first medical treatment was sought for the named Sickness while coverage as to the person incurring the charges for the Sickness under this policy is in force.

For purposes of the Extension of Benefits, if an Insured Person is confined to a Hospital on the date his or her insurance terminates, charges incurred during the continuation of that Hospital Confinement shall also be included in the term "Expense", but only while they are incurred during the 90 day period following such termination of insurance.

Covered Percentage means that part of the Covered Charge that is payable by the Company.

Deductible means the amount of Expenses for covered services and supplies which must be incurred by the Insured Person before specified benefits become payable.

Dependent means: (a) the Insured Student's spouse or the Insured Student's civil union partner; or (b) the Insured Student's Children. Coverage for the Insured Student's children shall terminate no earlier than the Policy Termination Date on or after whichever of the following occurs first, the date on which the child: (a) attains the age of 26; or (b) becomes covered under a group health plan through his or her own employment. Coverage for newborn children will consist of coverage for Sickness or Accident, including necessary care or treatment of congenital defects, birth abnormalities, or premature birth. Such coverage will start from the moment of birth, if the Insured Student is already insured for dependent coverage when the child is born. If the Insured Student does not have dependent coverage when the child is born, We cover the newborn child for dependent benefits from and after the moment of birth, or any minor child placed with an Insured Student for adoption for dependent benefits from and after the moment the child is placed in the physical custody of the Insured Student for adoption. To continue the newborn child's dependent benefits past the first 31 days, the Insured Student must notify Us in writing within 31 days of the child's birth.

The term "children" includes an Insured Student's biological children; step-children; adopted children from the date of placement in the Insured Student's home.

A child's coverage will not end because the child has reached the age limit shown above, if he or she: (a) is not able to earn his or her own living as a result of physical or mental handicap; and (b) became

so handicapped before reaching the age limit; and (c) is chiefly dependent on the Insured Student for support and maintenance.

Within 31 days after the child reaches the age limit, the Insured Student must send us proof of the child's dependency or handicap. We may ask for more proof of the child's dependency and handicap, but We will not ask for proof more frequently than annually after the two year period following the child's attainment of the limiting age.

Any Dependent on active duty in any military, naval, or air force of any country is not eligible for coverage under this Policy.

Doctor as used herein means: (a) a legally qualified physician licensed by the state in which he or she practices; or (b) a practitioner of the healing arts performing services within the scope of his or her license as specified by the laws of the state of residence of such practitioner; or (c) a certified nurse midwife while acting within the scope of that certification.

Elective Treatment means medical treatment which is not necessitated by a pathological change in the function or structure in any part of the body occurring after the Insured Person's Effective Date of coverage.

Elective Treatment includes, but is not limited to: tubal ligation; vasectomy; breast reduction; breast implants; sexual reassignment surgery; impotence (organic or otherwise); submucous resection and/or other surgical correction for deviated nasal septum, other than necessary treatment of covered chronic purulent sinusitis; treatment for weight reduction; learning disabilities; immunizations; and routine physical examinations.

Experimental or Investigational Care means a service or supply: (a) that We, in Our discretion, determine is not commonly and customarily recognized as being safe and effective for the particular diagnosis or treatment; or (b) which requires approval by any governmental authority and such approval has not been granted before the service or supply is furnished.

We may rely upon the advice of medical consultants and commonly recognized national medical organizations in determining which services or supplies are experimental or investigational.

"Experimental or Investigational Care" will not include any drug, or any Medically Necessary services associated with the administration of such drug, prescribed for the treatment of a condition even though that drug is not approved by the FDA for that particular condition as long as that drug is recognized for treatment of that condition:

- (a) In a standard reference compendium; or
- (b) Is recommended by scientific studies published in a United States peer-reviewed national professional journal.

We will not deny a procedure, treatment or the use of any drug as Experimental or Investigational Care if such procedure, treatment or drug, for the condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the FDA. Any Insured Person who has been diagnosed with a condition that creates a life expectancy in that person of less than two years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is Experimental or Investigational Care may request an expedited appeal as provided in Connecticut General Statutes section 38a-226c and may appeal a denial thereof to the Insurance Commissioner in accordance with the procedures established in section 38a-478n.

Hospital means a facility which meets all of these tests: (a) it provides inpatient services for the care and treatment of injured and sick people; and (b) it provides room and board services and nursing services 24 hours a day; and (c) it has established facilities for diagnosis and major surgery; and (d) it is supervised by a Doctor; and (e) it operates and is licensed as a Hospital under the laws of the jurisdiction in which it is located. Hospital also includes a licensed substance abuse treatment facility only when treatment for substance abuse or medical complications of alcoholism is rendered. Hospital also includes a

mobile field hospital, which is a modular, transportable facility used intermittently for the provision of medical services in the event of a public health or other emergency for isolation care purposes or triage treatment during a mass casualty event or for providing surge capacity for a hospital during a mass casualty event or infrastructure failure. Hospital does not include a place run mainly: (a) as a convalescent home; (b) as a nursing or rest home; or (c) as a hospice facility.

Hospital Confinement means a stay of 18 or more consecutive hours as a resident bed-patient in a Hospital.

Injury means bodily injury caused by an Accident, which is the sole cause of the Loss. All injuries due to the same or a related cause are considered one Injury.

Insured Person means an Insured Student and his/her covered Dependents while insured under this Policy.

Loss means medical expense covered by this Policy as a result of Injury or Sickness as defined in this Policy, and other expenses as specifically covered.

Medical Emergency means the unexpected onset of an Injury or Sickness which requires immediate or urgent medical attention which, if not provided, could result in a loss of life or serious permanent damage to a limb or organ or pain sufficient to warrant immediate care. A Medical Emergency does not include elective or routine care.

Medically Necessary means health care services that a Doctor, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating a sickness or an injury, or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site, and duration and considered effective for the patient's sickness or injury, and (c) not primarily for the convenience of the patient, physician, or other health care provider and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's sickness or injury. "Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

Per Condition Aggregate Maximum means for each Insured Person, the maximum amount of benefits payable for each Injury or Sickness under the Student Health Insurance Policy each Policy Year.

Policyholder means the institution indicated on the face page of the Plan.

Reasonable and Customary Expenses means fees and prices generally charged within the locality where performed for Medically Necessary services and supplies required for treatment of cases of comparable severity and nature.

Sickness means sickness or disease which is the sole cause of the Loss. Sickness includes both normal pregnancy and Complications of Pregnancy. All sicknesses due to the same or a related cause are considered one Sickness.

We, Us and **Our** mean the Combined Insurance Company of America. **You, Your** or **Yours** means the Insured Student.

Description of Accident and Sickness Insurance Benefits

Accident and Sickness Expense Benefits

Maximum Benefit \$50,000 per covered injury or sickness.

Payment will be made as allocated in the schedule of benefits for covered medical expenses incurred for an Injury or Sickness while insured under this Plan, not to exceed the Per Condition Aggregate Maximum of \$50,000.

Accident Expense Benefit

When, by reason of Injury, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay 100% of the Reasonable and Customary Expenses incurred up to the first \$1,000. Thereafter, We will pay 80% of the Reasonable and Customary Expense up to a maximum benefit of \$50,000 for any covered medical expense incurred as a result of a covered Accident. The Accident must have occurred while coverage under the Policy is in force as to the Insured Person incurring the expense, subject to the pre-existing condition limitation. Coverage includes: (a) treatment by a Doctor/surgeon; (b) Hospital Confinement; (c) nurse practitioner or RN; (d) x-rays; (e) operating room, anesthesia, laboratory; (f) prescribed medicines, plaster casts, surgical dressings; (g) ambulance.

Sickness Expense Benefit

When, by reason of Sickness, an Insured Person incurs expenses for hospital, surgical or medical treatment, services or supplies, We will pay for the Covered Percentage of the Covered Charges incurred within 52 weeks from the date of the first medical treatment for the Sickness as shown in the Plan of Insurance up to a maximum of \$50,000 per covered Sickness. The date of the first medical treatment for the Sickness must have occurred while coverage under this Policy is in force as to the Insured Person incurring the expenses. Charges applicable to this provision incurred during the continuation of coverage shall also be included in the term "Expense" but only while they are incurred within 52 weeks from the date of the first medical treatment for the Sickness.

SCHEDULE OF MEDICAL EXPENSE BENEFITS

ACCIDENT EXPENSE BENEFITS: This Plan provides benefits for a Covered Accident at 100% of the Reasonable and Customary Expense up to \$1,000. Once \$1,000 is reached, benefits are paid at 80% of the Reasonable and Customary Expense up to a maximum benefit of \$50,000 per Covered Accident. Please refer to the Limitations and Exclusions section of this brochure for specific benefit limitations subject to the terms and conditions of the Policy.

SICKNESS EXPENSE BENEFITS

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| Per Condition Aggregate Maximum | \$50,000 per Sickness |
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| Deductible , waived with referral from Student Health Center. | \$25 per Sickness |
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HOSPITAL EXPENSE BENEFITS

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| Hospital Room and Board Expense , Services include semi-private room, nursing services, special care unit. | 80% of Reasonable and Customary Expense |
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| Hospital Miscellaneous Expense , Services include Pre-Admission Testing, anesthesia, operating room, diagnostic x-ray, laboratory tests, prescribed drugs & medicines, dressings, supplies, physical & occupational therapy, other necessary prescribed hospital expenses. | 80% of Reasonable and Customary Expense |
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| In Hospital Doctor's Fees and Medical Expense , Limited to one visit per day. Does not apply when related to surgery. | 100% of Reasonable and Customary Expense up to \$100 for the first visit, then up to \$40 per visit thereafter |
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SURGICAL EXPENSE BENEFITS (INPATIENT OR OUTPATIENT)

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| Surgical Expense Benefit , When Injury or Sickness requires multiple Surgical Procedures through the same incision, We will pay an amount not less than that for the most expensive procedure being performed. Multiple Surgical Procedures performed during the same operating session but through different incisions shall be reimbursed in an amount not less than the Covered Percentage of the Covered Charge of the most expensive Surgical Procedure then being performed, and with regard to the less expensive Surgical Procedure in an amount equal to 50% of the Covered Percentage for the Covered Charge for these procedures. | 80% of Reasonable and Customary Expense |
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| Assistant Surgeon Expense; Anesthetist Expense | 30% of the Paid Surgical Expense |
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OUTPATIENT BENEFITS

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| Outpatient Miscellaneous Expense , Services include allergy testing, diagnostic x-ray & laboratory, physical therapy (limited to one visit per day), radiation therapy, chemotherapy, hospital emergency room, hospital outpatient department, doctor services, speech therapy, chiropractic services, consultant services and neuro-psychological testing of a child to assess the extent of any cognitive or developmental delays in such child due to chemotherapy or radiation treatment for each child diagnosed with cancer on or after January 1, 2000, hypodermic needles or syringes for the purpose of administering medications for covered medical conditions. | When the Student Health Center (SHC) is closed & Preferred Care Medical (PCM) is used, covered 90% of Reasonable and Customary Expense up to \$5,000 maximum per sickness. When a Provider other than the SHC, or PCM is used, covered 80% of the Reasonable and Customary Expense up to \$5,000 maximum per Sickness after a \$25 Deductible. |
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| Doctor's Office Visit Expense Benefit (including Chiropractor and Physical Therapy visits and outpatient mental health services), included in Outpatient Miscellaneous Expense Maximum, limited to one visit per day. | When referred by the SHC: 100% of Reasonable and Customary Expense up to \$500, then 80% up to \$5,000 maximum per Sickness. When not referred by the SHC: 80% of Reasonable and Customary up to \$5,000 per sickness, not to exceed 5 visits per sickness |
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| Consultant Visit Expense Benefit , included in Outpatient Miscellaneous Expense Maximum. | 100% of Reasonable and Customary Expense up to \$250 maximum |
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| Pre-Admission Tests Expense Benefit | Paid under Outpatient Expense Maximum |
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SCHEDULE OF MEDICAL EXPENSE BENEFITS (Con't)

MENTAL & NERVOUS CONDITIONS EXPENSE BENEFIT (Refer to page 8 for details)

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| Inpatient Mental Health Expense Benefit | Paid as any other Sickness |
| Outpatient Mental Health Expense Benefit | Paid as any other Sickness |
| STATE MANDATED BENEFITS (Refer to page 6 for complete descriptions) | |
| Accidental Ingestion of a Controlled Drug Expense Benefit | Paid as any other Sickness up to 30 days maximum for Inpatient treatment or \$500 maximum per Policy Year for Outpatient treatment |
| Alcohol and Drug Abuse Expense Benefit | Paid as any other Sickness |
| Ambulance Expense Benefit | The maximum allowable rate established by the Department of Health |
| Blood Lead Screening Expense Benefit | Paid as any other Sickness |
| Cancer Clinical Trials Expense Benefit | Paid as any other Sickness |
| Cancer Screening Tests Expense Benefit | Paid as any other Sickness |
| Craniofacial Disorders Expense Benefit | Paid as any other Sickness |
| Diabetes Expense Benefit | Paid as any other Sickness |
| Dental Anesthesia Expense Benefit (Refer to page 7 for details.) | Paid as any other Sickness |
| Early Intervention Services | Paid as any other Sickness, up to a maximum benefit of \$6,400 per covered Dependent child per year, and an aggregate benefit of \$19,200 per covered Dependent child over the total three-year-period |
| Epidermolysis Bullosa Treatment | Paid as any other Sickness |
| Pediatric Preventive Care | Paid as any other Sickness |
| Private Duty Nursing | Not Covered |
| Hospice | Not Covered |
| Acupuncture | Not Covered |
| Hearing Aid Expense Benefit for Dependent Children age 12 and under | 100% of Reasonable and Customary to \$1,000 within a 24 month period |
| Home Health Care Expense | After a \$50 per year deductible, 75% of Reasonable and Customary Expense up to 80 visits per Policy Year (\$200 per Policy Year for medical social services for a terminally ill Insured Person) |
| Infertility Expense Benefit | Paid as any other Sickness |
| Inherited Metabolic Disease Expense Benefit | Paid as any other Sickness |
| Tumor, Leukemia and Breast Reconstruction Expense Benefit | Paid as any other Sickness |
| Leukemia Expense Benefit | Paid as any other Sickness |
| Lyme Disease Expense Benefit | Paid as any other Sickness |
| Mastectomy Inpatient Expense Benefit | Paid as any other Sickness |
| Maternity Coverage | Paid as any other Sickness |
| Mental and Nervous Conditions Expense Benefit | Paid as any other Sickness |
| Occupational Therapy Expense Benefit | Paid as any other Sickness |
| Ostomy Expense Benefit | Paid as any other Sickness |
| Pain Management Expense Benefit | Paid as any other Sickness |
| ADDITIONAL BENEFITS | |
| Accident Dental Expense, Injury to sound natural teeth | 80% of Reasonable and Customary Expense |
| Emergency Medical Evacuation, must be approved in advance by the Company | 100% of actual Expense up to \$25,000 |
| Repatriation of Remains, must be approved in advance by the Company | 100% of actual Expense up to \$15,000 |
| Voluntary Termination of Pregnancy | 100% of Reasonable and Customary Expenses |
| Intercollegiate Sports Injury Expense Benefit | Covered as any other Injury up to \$500 |

Mandated Benefits

Accidental Ingestion of a Controlled Drug Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for emergency medical care arising from the accidental ingestion or consumption of a Controlled Drug, as follows:

In-Patient: In the event expenses are incurred in connection with confinement as an in-patient in a Hospital (including a state institution), then such expenses are covered to the same extent as a Sickness. The maximum period benefits are payable is limited to 30 days in any Policy Year.

Out-Patient: With respect to those covered expenses which are incurred by the Insured Person while other than an in-patient in a Hospital, expenses are covered to the same extent as any other Sickness, up to a maximum of \$500.00 per Policy year.

Alcohol & Drug Abuse Expense Benefit

Such charges are treated the same as charges incurred for treatment of any other Sickness under the Policy.

If an Insured Person requires treatment on account of alcoholism, Alcohol Abuse, Drug Abuse or drug dependency, We will pay for such treatment as follows:

Benefits for Inpatient Services: We will pay the Covered Percentage of the Covered Charges incurred for inpatient care in a Hospital or substance abuse treatment facility for the treatment of substance abuse or medical complications of alcoholism when diagnosed or recommended by a licensed Physician. Such charges are treated the same as charges incurred for treatment of any other Sickness under the Policy.

Benefits for Outpatient Services: We will pay the Covered Percentage of the Covered Charges incurred as shown in the Schedule of Medical Benefits for covered outpatient services for the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency.

Outpatient Treatment and Doctor services include charges for services rendered in a Doctor's office or by an outpatient treatment department of a Hospital, community mental health facility or alcoholism treatment facility, so long as the Hospital, community mental health facility or alcoholism treatment facility is approved by the Joint Commission on the Accreditation of Hospitals or certified by the Department of Health. The services must be legally performed by or under the clinical supervision of a licensed Doctor or a licensed psychologist who certifies every three months that the Insured Person needs to continue such treatment.

Ambulance Expense Benefit

When Medically Necessary, by reason of Accident (or Sickness), an Insured Person requires the use of an ambulance, We will pay the Covered Percentage of the Covered Charges incurred as shown in the Plan of Insurance up to the maximum allowable rate established by the Connecticut Department of Public Health.

Ambulance Service is transportation by a vehicle designed, equipped and used only to transport the sick and injured to a Hospital or between Hospitals. Surface trips must be to the closest local facility that can provide the covered service appropriate to the condition. If there is no such facility available, coverage is for trips to the closest facility outside the local area. Air transportation is covered when Medically Necessary because of a life threatening Injury (or Sickness). Air ambulance is air transportation by a vehicle designed, equipped and used only to transport the sick and injured to and from a Hospital for inpatient care.

We will pay the Ambulance Service provider directly if such provider has not received payment for such service from any other source. What We pay is shown in the Schedule of Medical Benefits.

Blood Lead Screening Expense Benefit *Paid as any other Sickness*

We will pay the Covered Percentage of the Covered Charges incurred for lead screening.

Covered Services will include:

- (a) lead screening at least annually for each child nine to thirty-five months of age;
- (b) lead screening for any child thirty-six to seventy-two months of age, who has not been previously screened or for any child under seventy-two months of age, if clinically indicated as determined by a Doctor;
- (c) medical risk assessment at least annually for each child thirty-six to seventy-one months of age;
- (d) medical risk assessment at any time for any child thirty-six months of age or younger who is determined by a Doctor to be in need of such risk assessment.

Cancer Clinical Trials Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Routine Patient Care Costs associated with Cancer Clinical Trials that are not eligible for reimbursement by an entity other than Us, including the entity sponsoring the cancer clinical trial.

Covered Charges also include hospital expenses for treatment at a non-network facility if (a) it is unavailable at a network facility and (b) the clinical trial sponsors are not paying for it. Coverage for treatment at a non-network facility will be provided at the network copayment, coinsurance and deductible.

Upon receipt of the standardized Connecticut Insurance Department form from a provider, hospital or institution seeking coverage for the Routine Patient Care Costs of an Insured Person in a Cancer Clinical Trial, We shall approve or deny coverage for such services within five business days of receiving such request and any other reasonable supporting materials requested by Us pursuant to Section 38a-504c, except that if We utilize independent experts to review such requests. We shall respond within ten business days. Requests for coverage of phase III clinical trials for the prevention of cancer pursuant to Section 38a-504a shall be approved or denied within fourteen business days. The Insured Person, or the provider with the Insured Person's written consent, may appeal any denial of coverage for Medical Necessity to an external, independent review pursuant to Section 38a-478n. Such external review shall be conducted by a properly qualified review agent whom the Connecticut Insurance Department has determined does not have a conflict of interest regarding the Cancer Clinical Trial. We cover such charges the same way We treat Covered Charges for any other Sickness.

Cancer Screening Tests Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for routine mammograms, pap smears and other cancer screening tests performed by a qualified facility or Physician. Covered charges include mammographic examinations to any woman as follows:

- (a) baseline mammogram for any woman who is thirty-five to thirty-nine years of age; and
 - (b) a mammogram every year for any woman who is forty years of age or older.
- Covered Charges also include comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse.

Covered Charges also include laboratory and diagnostic tests, including, but not limited to, prostate specific antigen (PSA) tests, to screen for prostate cancer for male Insured Persons who are symptomatic, whose biological father or brother has been diagnosed with prostate cancer, and for all male Insured Persons fifty years of age or older.

Covered Charges also include colorectal cancer screening, including, but not limited to, (a) an annual fecal occult blood test, and

- (b) colonoscopy, flexible sigmoidoscopy or radiologic imaging, in accordance with the recommendations established by the American

College of Gastroenterology, after consultation with the American Cancer Society, based on the ages, family histories and frequencies provided in the recommendations.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Craniofacial Disorders Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary orthodontic processes and appliances for treating craniofacial disorders in Insured Persons age 18 and younger. These processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. Coverage is not provided for cosmetic surgery.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Dental Anesthesia Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for general anesthesia, nursing and related Hospital services provided in conjunction with inpatient, outpatient or one-day dental services if deemed Medically Necessary by the treating dentist, or oral surgeon and the Insured Person's primary care Doctor, and the Insured Person is either: (a) determined by a licensed dentist, in conjunction with a licensed Doctor who specializes in primary care, to have a dental condition of significant dental complexity that it requires certain dental procedures to be performed in a hospital, or (b) a person who has a development disability, as determined by a licensed Doctor who specializes in primary care, that places the person at serious risk. We cover such charges the same way We treat Covered Charges for any other Sickness.

Diabetes Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Charges for laboratory and diagnostic tests and the Medically Necessary treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes. Such coverage shall include Medically Necessary equipment, in accordance with the Insured Person's treatment plan, drugs and supplies prescribed by a prescribing practitioner. Covered Charges also include outpatient self-management training for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin using diabetes if the training is prescribed by a licensed health care professional who has appropriate state licensing authority to prescribe such training. Outpatient self-management training includes, but is not limited to, education and medical nutrition therapy. Diabetes self-management training shall be provided by a certified, registered or licensed health care professional trained in the care and management of diabetes and authorized to provide such care within the scope of the professional's practice. Benefits shall cover:

- (a) initial training visits provided to an Insured Person after the Insured Person is initially diagnosed with diabetes that is Medically Necessary for the care and management of diabetes, including, but not limited to, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes, totaling a maximum of ten hours;
- (b) training and education that is Medically Necessary as a result of a subsequent diagnosis by a Physician of a significant change in the Insured Person's symptoms or condition which requires modification of the Insured Person's program of self-management of diabetes, totaling a maximum of four hours; and
- (c) training and education that is Medically Necessary because of the development of new techniques and treatment for diabetes totaling a maximum of four hours.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Epidermolysis Bullosa Treatment Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for wound care supplies that are Medically Necessary for the treatment of Epidermolysis Bullosa and are administered under the direction of a Doctor.

Hearing Aid Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for hearing aids for covered Dependent children twelve years of age or younger, up to a maximum benefit of \$1,000 within a twenty-four month period. We cover such charges the same way We treat Covered Charges for any other Sickness.

Home Health Care Expense

When, by reason of covered Injury or Sickness, an Insured Person incurs expenses for covered home health care service, We will pay, after a \$50.00 deductible per policy year, 75% of the Reasonable and Customary Charge incurred, up to a maximum of 80 home health care visits in any calendar year or in any continuous period of 12 months for each Insured Person. Each four hours of home health aide service will count as one visit. In the case of a terminally ill Insured Person, no more than \$200 for medical social services per policy year. This benefit is not subject to the Policy Deductible.

Infertility Expense Benefit

We will pay the Covered Charges for Medically Necessary expenses for the diagnosis and treatment of Infertility, including, but not limited to, ovulation induction, intrauterine insemination, in-vitro fertilization, uterine embryo lavage, embryo transfer, gamete intra-fallopian transfer, zygote intrafallopian transfer and low tubal ovum transfer.

Prescription drugs related to the diagnosis and treatment of Infertility are included under this benefit.

Coverage for Infertility is subject to the following limitations for all treatment or procedures combined under this Student Health Policy or Policies or any other Health Insurance issued before this Policy:

1. Coverage ceases on the Insured Person's fortieth (40) birthday;
2. Ovulation induction has a lifetime maximum benefit of four cycles;
3. Intrauterine insemination has a lifetime maximum benefit of three cycles;
4. There is a lifetime benefit maximum of two cycles, with not more than two embryo implantations per cycle for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer or low tubal ovum transfer, provided each such fertilization or transfer shall be credited toward such maximum as one cycle;
5. Coverage for in-vitro fertilization, gamete intra-fallopian transfer, zygote intra-fallopian transfer and low tubal ovum transfer is provided for only those individuals who have been unable to conceive or produce conception or sustain a successful pregnancy through less expensive and medically viable infertility treatment or procedures covered under this Policy. However, coverage shall not be denied to any individual who for goes a particular infertility treatment or procedure if the individual's physician determines such treatment or procedure is likely to be unsuccessful;
6. Treatment or procedures must be performed at facilities that conform to the standards and guidelines developed by the American Society of Reproductive Medicine or the Society of Reproductive Endocrinology and Infertility;
7. The Insured Person seeking the coverage must have been covered under this Policy for at least twelve (12) months; and
8. The Insured Person seeking the coverage must disclose on a form prescribed by the Insurance Commissioner any previous Infertility treatment of procedures for which they received coverage under a different health insurance policy.

Treatment or Services not covered under this Policy are as follows:

1. Cost of donor sperm or an ovum donor when oocyte is retrieved from someone other than recipient;
2. Sperm, embryo(s), reproductive tissue, testicular/ovarian, oocyte storage costs;
3. Cryopreservation of embryos, oocytes (eggs), sperm or other reproductive tissue;
4. Ovulation predictor kits;
5. Any infertility treatment if the Insured Person has undergone voluntary sterilization procedure (tuba) ligation, fulguration, vasectomy, Essure® insertion or vasectomy) unless the voluntary sterilization procedure has been successfully reversed;
6. Reversal of permanent sterilization procedures;
7. Cloning;
8. Sex change procedures;
9. Services for partners, spouses, surrogates and the maternity expenses of gestational carriers not insured by Us are excluded;
10. All costs associated with surrogate motherhood. This does not include retrieval of the egg or sperm from the Insured Person but does include charges for implanting the egg or sperm.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Infertility means the condition of a presumably healthy individual who is unable to conceive or produce conception or sustain a successful pregnancy during a one year period.

Inherited Metabolic Disease Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Amino Acid Modified Preparations and Low Protein Modified Food Products for the Medically Necessary treatment of Inherited Metabolic Diseases if the Amino Acid Modified Preparations or Low Protein Modified Food Products are prescribed for the therapeutic treatment of Inherited Metabolic Diseases and are administered under the direction of a Physician. Also covered are charges for Specialized Formulas when such Specialized Formulas are Medically Necessary for a disease or condition and are administered under the direction of a Physician.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Inherited Metabolic Disease includes (a) a disease for which newborn screening is required under section 19a-55, as amended; and (b) cystic fibrosis.

Tumor, Leukemia and Breast Reconstruction Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary treatment of leukemia, including outpatient chemotherapy, reconstructive surgery, cost of any nondental prosthesis, including any maxillo-facial prosthesis used to replace anatomic structures lost during treatment for head and neck tumors or additional appliances essential for the support of such prosthesis, outpatient chemotherapy following surgical procedures in connection with the treatment of tumors, and a wig if prescribed by a licensed oncologist for a patient who suffers hair loss as a result of chemotherapy. Coverage also includes the reasonable cost of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a nondiseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under this Plan. For the purpose of this coverage, reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

The Maximum Benefit per Policy Year shall be \$1,000 for the costs of removal of any breast implant, \$500.00 for the surgical removal of tumors, \$500.00 for reconstructive surgery, \$500.00 for outpatient chemotherapy, \$350.00 for a wig, and \$300.00 for prosthesis, except

that for purposes of the surgical removal of breasts due to tumors the Maximum Benefit per Policy Year shall be \$300 for each breast removed.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Lyme Disease Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Lyme disease treatment including not less than thirty days of intravenous antibiotic therapy, sixty days of oral antibiotic therapy, or both, and further treatment if recommended by a board certified rheumatologist, infectious disease specialist or neurologist licensed in accordance with chapter 370 or who is licensed in another state or jurisdiction whose requirements for practicing in such capacity are substantially similar to or higher than those of Connecticut.

We cover such charges the same way We treat Covered Charges for any other Sickness.

Mastectomy Inpatient Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for a minimum of forty-eight hours of inpatient care following a mastectomy or lymph node dissection or any longer period of inpatient care recommended by the Insured Person's attending Physician.

Maternity Coverage

Normal pregnancy, complications of pregnancy, resulting childbirth, miscarriage or termination of pregnancy (except for elective abortion) on the same basis as a covered Sickness. Coverage includes a minimum inpatient stay of 48 hours for a vaginal delivery and 96 hours for a caesarean delivery. If the mother and newborn are discharged prior to this time frame, after consultation with the Doctor, this plan will cover 2 follow up visits. The first visit must be within 48 hours of discharge and the second visit within 7 days.

Mental & Nervous Conditions Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for the Medically Necessary diagnosis and treatment of mental or nervous conditions as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". "Mental or nervous conditions" does not include (1) mental retardation, (2) learning disorders, (3) motor skills disorders, (4) communication disorders, (5) caffeine-related disorders, (6) relational problems, and (7) additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders". In the case of benefits payable for the services of a licensed Physician, such benefits shall be payable for the same services when such services are lawfully rendered by a psychologist licensed under the provisions of chapter 383 or by such a licensed psychologist in a licensed hospital or clinic.

In the case of benefits payable for the services of a licensed Physician or psychologist, such benefits shall be payable for the same services when such services are rendered by:

- (a) A clinical social worker who is licensed under the provisions of chapter 383b and who has passed the clinical examination of the American Association of State Social Work Boards and has completed at least two thousand hours of the post-master's social work experience in a nonprofit agency qualifying as a tax-exempt organization, in a municipal, state or federal agency or in an institution licensed by the Dept. of Public Health under section 19a-490;
- (b) A social worker who was certified as an independent social worker under the provisions of chapter 383b prior to October 1, 1990;
- (c) A licensed marital and family therapist who has completed at least two thousand hours of the post-masters marriage and family therapy work experience in a nonprofit agency qualifying as a

tax-exempt organization, in a municipal, state or federal agency or in an institution licensed by the Department of Public Health under section 19a-490;

- (d) A marital and family therapist who was certified under the provisions of chapter 383a prior to October 1, 1992;
- (e) A licensed alcohol and drug counselor, as defined in section 20-74s, or a certified alcohol and drug counselor, as defined in section 20-74s; or
- (f) A licensed professional counselor.

In the case of benefits payable for the services of a licensed Physician, such benefits shall be payable for: (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of a psychiatrist, Physician, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement above; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement above; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement above. In the case of benefits payable for the services of a licensed psychologist, such benefits shall be payable for: (A) services rendered in a child guidance clinic or residential treatment facility by a person with a master's degree in social work or by a person with a master's degree in marriage and family therapy under the supervision of such licensed psychologist, licensed marital and family therapist or licensed clinical social worker who is eligible for reimbursement above; (B) services rendered in a residential treatment facility by a licensed or certified alcohol and drug counselor who is eligible for reimbursement above; or (C) services rendered in a residential treatment facility by a licensed professional counselor who is eligible for reimbursement above.

In the case of benefits payable for the service of a licensed Physician practicing as a psychiatrist or a licensed psychologist, such benefits shall be payable for outpatient services rendered: (1) in a nonprofit community mental health center, as defined by the Department of Mental Health and Addiction Services, in a nonprofit licensed adult psychiatric clinic operated by an accredited Hospital or in a residential treatment facility; (2) under the supervision of a licensed Physician practicing as a psychiatrist, a licensed psychologist, a licensed marital and family therapist, a licensed clinical social worker, a licensed or certified alcohol and drug counselor, or a licensed professional counselor who is eligible for reimbursement above; and (3) within the scope of the license issued to the center or clinic by the Department of Public Health or to the residential treatment facility by the Department of Children and Families.

In the case of any Insured Person admitted to a state institution or facility administered by the Department of Mental Health and Addiction Services, Department of Public Health, Department of Children and Families or the Department of Mental Retardation, the state shall have a lien upon the proceeds of any coverage available to such person or a legally liable relative of such person under the terms of this benefit section, to the extent of the per capita cost of such person's care. In the case of benefits based upon confinement in a residential treatment facility, such benefits shall be payable in situations in which the insured has a serious mental or nervous condition that substantially impairs the insured's thoughts, perception of reality, emotional process or judgment or grossly impairs the behavior of the insured, and, upon an assessment of the insured by a physician, psychiatrist, psychologist or clinical social worker, cannot appropriately, safely or effectively be treated in an acute care, partial hospitalization, intensive outpatient or outpatient setting.

In the case of Autism Spectrum Disorders, We will cover physical therapy, speech therapy and occupational therapy services.

The services rendered for which benefits are to be paid for confinement in a residential treatment facility must be based on an individual treatment plan. For purposes of this benefit, the term "individual

treatment plan" means a treatment plan prescribed by a physician with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

We will not, through the use of a drug formulary, list of covered drugs or any other means: (A) limit the availability of psychotropic drugs that are the most effective therapeutically indicated pharmaceutical treatment with the least probability of adverse side effects; or (B) require utilization of psychotropic drugs that are not the most effective therapeutically indicated pharmaceutical treatment with the least probability of adverse side effects. Nothing in this benefit shall be construed to limit the authority of a Physician to prescribe a drug that is not the most recent pharmaceutical treatment.

We cover such charges the same way We treat Covered Charges for any other Sickness.

What We pay is shown in the Plan of Insurance.

Occupational Therapy Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Occupational Therapy provided in private practice or in a Health Care Facility or in a Partial Hospitalization program on an exchange basis. We cover such charges the same way We treat Covered Charges for any other Sickness.

Ostomy Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred up to \$1,000 per Policy Year for Medically Necessary appliances and supplies relating to an ostomy including, but not limited to, collection devices, irrigation equipment and supplies, skin barriers and skin protectors. Ostomy includes colostomy, ileostomy and urostomy. Payments under this benefit shall not be applied to any policy maximums for durable medical equipment. We cover such charges the same way We treat Covered Charges for any other Sickness.

Pain Management Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Pain treatment ordered by a Pain Management Specialist which may include all Medically Necessary means to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures. We cover such charges the same way We treat Covered Charges for any other Sickness.

Early Intervention Services Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for Medically Necessary early intervention services provided as part of an individualized family service plan pursuant to section 17a-248e. Such coverage shall provide (a) coverage for such services provided by qualified personnel, as defined in Section 17a-248, for a covered Dependent child from birth until the child's third birthday, and (b) a maximum benefit of \$6,400 per covered Dependent child per year and an aggregate benefit of \$19,200 per covered Dependent child over the total three-year period. No payment made under this benefit shall be applied against any maximum lifetime or annual limits specified in the Policy. We cover such charges the same way We treat Covered Charges for any other Sickness.

Preventive Pediatric Care Expense Benefit

We will pay the Covered Percentage of the Covered Charges incurred for a covered Dependent child from the moment of birth through age 6 years for Preventive Pediatric Care. Preventive Pediatric Care shall include 13 visits at approximately the following age intervals: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years and 6 years. Services to be covered at each visit include a history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards. Benefits are limited to one visit payable to one provider for all of the services provided at each visit cited in this provision. We cover such charges the same way We treat Covered Charges for any other Sickness.

Preventive Pediatric Care means Physician-delivered or Physician-supervised services which shall include coverage for services delivered at the intervals and scope stated in this provision.

Emergency Medical Evacuation Expense Benefit

This benefit applies to Domestic Students and International Students while insured under this Plan. We will pay for benefits for the Covered Expenses incurred, up to \$25,000 if any Injury or Sickness results in the Emergency Medical Evacuation of the Insured Person. Emergency Medical Evacuation means: (a) the Insured Person's medical condition warrants immediate Transportation from the place where the Insured Person is injured or ill to the nearest Hospital or home residence where appropriate medical treatment can be obtained; or (b) for International Students after being treated at a local Hospital; the Insured Person's medical condition warrants Transportation to his/her Home Country to obtain further medical treatment to recover. All Transportation arrangements made for evacuating the Insured Person must be: (a) by the most direct and economical conveyance; and (b) approved in advance by the Company. Expenses for special transportation must be: (a) recommended by the attending Doctor; or (b) required by the standard regulations of the conveyance transporting the Insured Person. Special transportation includes, but is not limited to: air ambulance, land ambulance, and private motor vehicle. Expenses for medical supplies and services must be recommended by the attending Doctor.

Repatriation of Remains Expense Benefit

This benefit applies to Domestic Students and International Students while insured under this Plan. In the event of the death of an Insured Person, We will pay the actual charges up to a maximum of \$15,000 for preparation and transportation of the Insured Person's remains to his or her home country. This will be in accord with all legal requirements in effect at the time the body remains are to be returned to his or her Home Country. The death must occur while the person is insured for this benefit. Covered expenses include expenses for embalming, cremation, coffins, and transportation. Repatriation of remains must be approved in advance by the Company.

International Assistance Program

The International Assistance Program (IAP) is included in the Student Insurance Plan that provides access to a 24-hour worldwide assistance network, On Call International, for emergency assistance anywhere in the world. Simply call the assistance center collect. The multilingual staff will answer your call and immediately provide reliable, professional and thorough assistance. The following services are included in this Plan:

1. Referral to the nearest, most appropriate medical facility, and/or Provider.
2. Medical monitoring by board certified emergency physicians in the United States.
3. Urgent message relay between family, friends, personal physician, school, and Insured.
4. Guarantee of payment to Provider and assistance in coordinating insurance benefits.
5. Arranging and coordinating emergency medical evacuations and repatriation of remains.
6. Emergency travel arrangements for disrupted travel as the consequence of a medical emergency.
7. Referral to legal assistance.
8. Assistance in locating lost or stolen items including lost ticket application processing.

Contact On Call International for any of these services:
Toll Free from U.S. and Canada: 1-800-850-4556
Dial Direct or Call Collect Worldwide: 1-603-898-9159 or
Contact our website: www.oncallinternational.com.

24-hour Nurse Advice Line

Students may utilize the Nurse Advice Line when the school health clinic is closed or anytime they need confidential medical advice. ON CALL provides Members with clinical assessment, education and general health information. This service shall be performed by a registered Nurse Counselor to assist in identifying the appropriate level and source(s) of care for members (based on symptoms reported and/or health care questions asked by or on behalf of Members). Nurses shall not diagnose Members ailments. Students must be enrolled in the Student Health Insurance Plan in order to be eligible to utilize the Nurse Advice program, which is sponsored by the school. This program gives students access to a toll-free nurse information line 24-hours a day, 7 days a week. One phone call is all it takes to access a wealth of useful health care information at 1-800-850-4556.

Pre-existing Condition Limitation

Pre-existing Condition is a condition, whether physical or mental, for which medical advice, diagnosis care, or treatment was recommended or received during the six (6) months prior to the Effective Date of the Insured Person's coverage under the Policy. The Pre-existing Condition Waiting Period is twelve (12) months. If an Insured Person receives treatment or service for a Pre-existing Condition: (a) We will not pay benefits for such condition until the day after a twelve (12) consecutive month period has passed from the Insured Students effective date, and (b) We will pay only for loss or expense incurred after such twelve (12) consecutive month period. However, the Pre-Existing Waiting Period shall be reduced by the period of time and Insured Person was covered under prior Creditable Coverage, provided the preceding coverage was continuous to a date not less than 120 days prior to their effective date of coverage under the Policy or 150 days if their preceding coverage was terminated due to an involuntary loss of employment, and provided the Insured Person applied for this coverage within 30 days of their initial eligibility. Payment will be in accord with the provisions of the Policy. If the Insured Person has a longer lapse in coverage, the Pre-Existing Condition Waiting Period will have to be satisfied again.

No Pre-existing Conditions limitation shall apply to Insured Persons who are 18 years of age and younger.

Creditable Coverage means prior health benefits coverage that may include any of, or a combination of the following: (a) A group health plan; (b) A health insurance plan or health maintenance organization (HMO) plan; (c) An individual health insurance policy; (d) COBRA continuation of coverage; (e) A health plan under Chapter 55, Title 10, United State Code pertaining members of the uniformed services of the United States; (f) Medicare or Medicaid; (g) A medical care program of the Indian Health Service or of a tribal organization; (h) A state health benefits risk pool; (i) A health plan offered under FEHBP (chapter 89 of Title 5, United States Code); (j) A health plan under section 5(e) of the Peace Corps Act; or (k) A public health plan.

Conformity with State Statutes

Any provision of this Plan which, on the Policy Effective Date, is in conflict with the statutes of the state in which the Insured Person resides on such date, is hereby amended to conform to the minimum requirements of such statutes.

Continuous Insurance

Any Insured Person who has continuous coverage under this Plan or any Prior Plan from one year to the next shall be covered for conditions

first manifesting themselves while Continuously Insured, except for benefits payable under prior policies in the absence of this Plan. Prior Plan means the Student Health Insurance Policy or Policies issued to Wesleyan University immediately before this Policy or any Credible Coverage as defined in this Plan.

Exclusions and Limitations

1. Services normally provided without charge by the Policyholder's student health service center, infirmary, or Hospital, or by Health Care Providers employed by the Policyholder;
2. Organ transplants, including bone marrow, except as specifically provided;
3. Pre-existing Conditions as defined in this Policy;
4. Injury sustained or Sickness contracted while in service of the Armed Forces of any country, except as specifically provided. Upon the Insured Person entering the Armed Forces of any country, We will refund the unearned pro-rata premium to such Insured Person;
5. Cosmetic surgery, except as the result of covered Injury occurring while this Policy is in force as to the Insured Person. This exclusion shall also not apply to cosmetic surgery which is reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved body part, and reconstructive surgery because of congenital disease or anomaly of a covered Dependent child which has resulted in a functional defect;
6. Injury or Sickness for which benefits are paid under any Workers' Compensation or Occupational Disease Law;
7. Expense incurred as the result of dental treatment, except as provided in the Sickness Dental Expense Benefit, if included in this Policy. This exclusion does not apply to treatment resulting from Injury to natural teeth;
8. Expense incurred after the date insurance terminates for an Insured Person except as may be specifically provided in the Extension of Benefits Provision, when applicable;
9. Injury or Sickness resulting from declared or undeclared war; or any act thereof;
10. Charges for treatment of any Injury or Sickness due to an Insured Person's commission of a felony. However, Injury sustained where such person has an elevated blood alcohol content in excess of the legal limit, or while under the influence of intoxicating liquor or any drug or both is not excluded;
11. Injury due to participation in a riot, which means voluntarily taking part in a civil disturbance with the intent of causing personal injury and/or property damage to nonparticipants. However, Injury sustained where such person has an elevated blood alcohol content in excess of the legal limit, or while under the influence of intoxicating liquor or any drug or both is not excluded;
12. Charges for which Insured Persons have no legal obligation to pay in absence of this or like coverage;
13. For services or supplies rendered by a close relative of the Insured Person. By "close relative" We mean an Insured Person's spouse, children, parents, brothers and sisters;
14. For services, supplies or treatment, including any period of Hospital Confinement, which were not recommended, approved and certified as necessary and reasonable by a Doctor; or expenses non-medical in nature;
15. Expense incurred for eye examinations or prescriptions, eyeglasses, and contact lenses (except for sclera shells which are intended for use of corneal bandages), eye refractions, vision therapy, multiphasic testing, or lasix or other vision procedures except as required for repair caused by a covered Injury;

16. Treatment provided in a governmental Hospital unless there is a legal obligation to pay such charges in the absence of insurance;
 17. Services not Medically Necessary;
 18. Accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route;
 19. Hearing aids, including exams for fitting, except as required to correct damage caused by an Injury which occurs while the patient is covered by this Plan, provided they are obtained within four months of the date of the Injury; except as otherwise stated in this Plan, except as mandated by Section 38a-490b of the Connecticut Insurance Law;
 20. Orthotic devices or prosthetics other than those mandated by Section 38a-504 of the Connecticut Insurance Law;
 21. This insurance plan does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit Us from providing insurance, including, but not limited to, the payment of claims.
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Reimbursement & Subrogation

If We pay covered expenses for an accident or injury You incur as a result of any act or omission of a third party, and You later obtain recovery from the third party, You are obligated to reimburse Us for the expenses paid to the extent permitted by law. We may also take subrogation action directly against the third party. Our Reimbursement rights are limited by the amount You recover. Our Reimbursement and Subrogation rights are subject to deduction for the pro-rata share of Your costs, disbursements and reasonable attorney fees. You must cooperate with and assist Us in exercising Our rights this provision and do nothing to prejudice Our rights.

Termination of Insurance

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

Extension of Benefits

If an Insured Person is confined to a hospital on the day his or her insurance terminates, expenses incurred after such termination date and during the continuance of that hospital confinement shall be payable in accordance with the Plan, but only while they are incurred during the 90 day period following such termination of insurance.

Claims Procedure

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

1. Written notice of claim must be given to Us within 30 days after the occurrence or commencement of any Loss covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant or the beneficiary to Us at Our Administrative Office or to any authorized agent, with information sufficient to identify the Insured Person, shall be deemed notice to Us. If a student is submitting the claim, a copy should be retained and claims should be mailed to the Claims Administrator, Klais & Company Inc., at the address on the back cover of this Brochure.
2. Providers should submit claims within 90 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. If a student is

submitting the claim, a copy should be retained and claims should be mailed to the Claims Administrator, Klais & Company, Inc., at the address on the back cover. Upon receipt of a written notice of claim, We will give the claimant such forms as are usually given by Us for filing proof of Loss. If such forms are not given within 15 days after receipt of such notice, he or she can fulfill the terms of this Policy as to proof of Loss by giving written proof of: (a) the occurrence of the Loss; (b) the nature of the Loss; and (c) the extent of the Loss.

3. Direct all questions regarding claim procedures, status of a submitted claim or payment of a claim, or benefit availability to the Claims Administrator, Klais & Company, Inc.
4. If you disagree with a claim payment decision, an Insured Person has the right to file an appeal. The process to file an appeal is as follows: (a) you must notify Klais & Company, Inc. within 30 days of the denial. Your claim appeal must be in writing, and clearly state that you are appealing the decision and requesting another review of your claim; and (b) your written appeal should provide specific documentation as to why you believe the decision to be in error, and any new medical information that will be helpful to Klais & Company, Inc. in considering the claim. Klais & Company, Inc. will respond in writing as to their decision. You can contact Klais & Company at 1-877-349-9017.

Any provisions of this Policy, which on its effective date, is in conflict with the statutes of the state in which the Policy is issued will be administered to conform with the requirements of the state statutes.

Appeals Procedure

If your claim is denied You will be notified of the reason with a description of any additional information necessary to appeal the denial. The process for filing a grievance with Combined Insurance Company of America or Our Plan Administrator, is as follows: (a) You may communicate a grievance to us orally, by calling Our Plan Administrator at 1-877-349-9017, email www.klais.com, or in writing; (b) the Insured Person, or a person acting on behalf of the Insured Person, including the Insured Person's health care provider, may make a request for review of a grievance; and (c) all reviews conducted under this provision shall be resolved not later than sixty (60) days from the date the Insured Person commences the complaint, unless an extension is requested by the Insured Person.

An Insured Person, or any provider acting on behalf of an Insured Person with the Insured Person's consent, who has exhausted the internal mechanisms provided by Us to appeal a determination not to certify an admission, service, procedure or extension of stay, may appeal such determination to the Connecticut Insurance Commissioner. To make such an appeal, an Insured Person or any provider acting on behalf of an Insured Person shall, within sixty (60) days from receiving a final written determination from Us, file a written request with the Commissioner in accordance with Section 38a-478n. We shall provide instructions on how to file such an appeal upon exhaustion of Our internal grievance procedure.

HIPAA Notice of Privacy Practices for Personal Health Information

Under HIPAA's Privacy Rule, We are required to provide you with notice of our legal duties and privacy practices with respect to personal health information. You should receive a copy of this notice with your enrollment materials. If, at anytime, you wish to request a copy of Combined Insurance Company of America's Privacy Notice, write to P.O. Box 6705 Scranton, PA 18505-0705 Attn: HIPAA Privacy Office, call 1-800-225-4500, select HIPAA or online at <http://www.combinedinsurance.com/policyholder-center/hipaa-insurance.htm>.

Questions? Need More Information?

For general information on benefits, on enrollment/eligibility questions, ID Cards or service issues, please contact:

Gallagher Koster, Inc.

500 Victory Road
Quincy, MA 02171
1-800-499-5062

Email: WesleyanStudent@gallagherkoster.com or
www.gallagherkoster.com/wesleyan

If you need medical attention before the ID card is received, benefits will be payable according to the Policy. You do not need an ID card to be eligible to receive benefits. Call Gallagher Koster to verify eligibility.

For information on a specific claim or to check the status of a claim, please contact:

Klais & Company, Inc.

Group #:
SH463M1 (Undergraduate)
SH463N1 (Graduate)
1867 West Market Street
Akron, OH 44313-6977
1-877-349-9017

Email: Klaisclaims@Klais.com

Register for StatusLink Claims Look-Up at www.Klais.com

CLAIM INFORMATION RECEIVED REGARDING MEDICAL TREATMENT IS STRICTLY CONFIDENTIAL

This Policy is Underwritten by:



Combined Insurance Company of America

Policy Number: CUH201887

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