



Designed especially
for the domestic
students attending
Private Secondary
Schools in Connecticut



DOMESTIC STUDENT

Blanket Injury & Sickness Insurance Plan

**Usual, Reasonable &
Customary Premier Plan**

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Privacy Policy

We know that your privacy is important to you, and we strive to protect the confidentiality of your nonpublic personal information. We do not disclose any nonpublic personal information about our customers or former customers to anyone, except as permitted or required by law. We believe we maintain appropriate physical, electronic and procedural safeguards to ensure the security of your nonpublic personal information. You may obtain a copy of our privacy practices by calling us toll-free at (800) 730-2417.

Eligibility

Who is Eligible: Any student, who was born in the United States, and whose permanent residence is in the United States, and who is affiliated with a private secondary school is eligible to purchase and participate in the plan.

To be Eligible, the Student Must Be: Enrolled in credit courses, a school sponsored camp or program of the participating institution or have been or will be enrolled in the school offered plan within 45 days.

The Company maintains its right to investigate student status to verify that the Policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is a refund of premium.

Effective and Termination Dates

Each participating private secondary school may have a different effective date. The Policy allows for an effective date no earlier than July 1, 2026, and not later than September 30, 2026. Coverage is available for 12 months from the school's effective date. The Covered Person should check with the school they are attending for specific dates of coverage.

Coverage becomes effective on the first day of the period for which premium is paid or at 12:01 am on the student's chosen effective date, whichever is later. Coverage terminates at 11:59 pm on the student's chosen termination date, the date the Covered Person ceases to be eligible, or at the end of the period through which premium is paid, whichever is earlier.

The coverage is provided by a Non-Renewable Term Policy.

Extension of Benefits after Termination

If a Covered Person is under the care and treatment of a Physician and Hospital confined on the Termination Date of the Policy, benefits will continue to be paid for that condition for a period of up to 90 days, or up to discharge from the Hospital or the maximum benefit has been paid, whichever occurs first.

General Features and Plan Specifications

Accident and Sickness Medical Expense Benefits

Area of Coverage	Worldwide
Maximum Benefit	Unlimited
Deductible	\$0
Coinsurance	100% of Usual, Reasonable and Customary charges, except as noted below

The coverage provides benefits for the Covered Medical Expenses incurred by a Covered Person for loss due to a covered Accident or Sickness up to the Maximum Benefit.

Schedule of Benefits

Benefits will be paid up to the Maximum Benefit for each service in the Schedule of Benefits, below:

Hospitalization and Inpatient Benefits

Benefit Coverage

Hospital Room & Board Benefit	100% of semi-private daily room rate
Hospital Miscellaneous Expense Benefit	100% of URC
Intensive Care Unit/Pediatric Care Benefit	100% of URC
Surgeon Benefit <i>Two (2) or more surgical procedures through the same incision will be considered as one (1) procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one (1) benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries</i>	100% of URC
Assistant Surgeon Benefit	100% of URC up to 30% of surgeon allowance
Anesthesia Benefit	100% of URC
Pre-Admission Testing Benefit – payable within 7 days prior to admission	100% of URC
Alcohol & Drug Abuse Expense Benefit	100% of URC
*Mental or Nervous Conditions Expense Benefit	100% of URC

Emergency Benefits

Benefit Coverage

*Emergency Room Benefit	100% of Negotiated Charge
*Ambulance Benefit	100% of Negotiated Charge
Emergency Dental Expense Benefit <i>Limited to Injury to Natural Teeth</i>	100% of URC

Outpatient Benefits

Benefit Coverage

Surgeon Benefit <i>Two (2) or more surgical procedures through the same incision will be considered as one (1) procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one (1) benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries</i>	100% of URC
Assistant Surgeon Benefit	100% of URC up to 30% of surgeon allowance
Anesthesia Benefit	100% of URC
Day Surgery Miscellaneous Benefit	100% of URC
Physician Visit	100% of URC
Consultant Physician Benefit	100% of URC
Nursing Services	100% of URC
*Hypodermic Needles / Injections Benefit <i>When administered in the Physician's office and charged on the Physician's statement</i>	100% of URC
*Wellness Medical Expense Benefit	100% of URC
Urgent Care Benefit	100% of URC
Interscholastic Sports Benefit <i>*Any other benefit payable in conjunction with this Benefit is subject to the maximum benefit amount defined herein</i>	100% of URC
Physiotherapy <i>60 visit maximum per Policy Year</i>	100% of URC

Benefit Coverage

*Durable Medical Equipment Expense Benefit	100% of URC
Diagnostic X-Ray and Laboratory Benefit	100% of URC
CT Scan, PET Scan or MRI Benefit	100% of URC
Radiation/Chemotherapy Therapy	100% of URC
Outpatient Prescription Drug Expense Benefit	\$0 copay per prescription limited to a 30-day supply
*Prescription Insulin and Medically Necessary Covered Noninsulin Drug	\$0 copay per prescription limited to a 30-day supply
*Diabetes Treatment Expense Benefit	100% of URC
*Maternity and Pre-Natal Care Expense Benefit	Covered as any other Sickness
Alcohol & Drug Abuse Expense Benefit	100% of URC
*Mental or Nervous Conditions Expense Benefit	100% of URC
Emergency Medical Evacuation/Return of Mortal Remains	100% of Actual Expense
*Hypodermic Needles/Injections Benefit	100% of URC
*Dental Services	100% of URC
*Early Intervention Services Benefit <i>Not subject to coinsurance, copayment, deductible or other out-of-pocket expense</i>	100% of URC
*Autism Spectrum Disorder Benefit	Same as any other Covered Sickness
*Long Term Antibiotic Therapy for the Treatment of Lyme Disease Benefit	100% of URC
*Craniofacial and Temporomandibular Joint (TMJ) Disorders Benefit	100% of URC
*Cancer Drugs Benefit	100% of URC
*Surgical Removal of Tumors; Treatment of Leukemia; Prosthetic Devices Benefit	100% of URC
*Mammography & Breast Ultrasound Benefit	100% URC
*Prosthetic Devices Benefit	100% of URC

Benefit Coverage

*Neuropsychological Testing Benefit	100% of URC
*Epidermolysis Bullosa Treatment Benefit	100% of URC
*Bone Marrow Testing Benefit	100% of URC
*Amino Acid Modified Preparation and Low Protein Modified Food Products Benefit	100% of URC
*Chiropractic Care Benefit	100% of URC
*Pain Management Benefit	100% of URC
*Hearing Aids Benefit	Paid the same as Durable Medical Equipment Benefit
*Experimental Treatment or Drug Benefit	Same as any other Covered Sickness
*Mobile Field Hospital Benefit	Same as any other Covered Sickness
*Accidental Ingestion or Consumption of a Controlled Drug Benefit	Same as any other Covered Sickness
*Telehealth Services Benefit	Same as any other Covered Sickness

****Asterisk indicates a state mandated benefit. All mandated state benefits, whether appearing here or not, will be provided per the laws of the state of Connecticut.***

Accidental Death and Dismemberment

If within 365 days from the date of an Accident covered by the Policy, an Injury from such Accident, results in Loss listed below, We will pay the percentage of the Principal Sum set opposite the loss in the table below. If the Covered Person sustains more than one such Loss as the result of one Accident, We will pay only one amount, the largest to which He/She/They is/are entitled. This amount will not exceed the Principal Sum which applies for the Covered Person.

Any benefit payable under this part will be in addition to any benefit otherwise payable under the Policy. This benefit is subject to all of the definitions, limitations, exclusions and other provisions of the Policy.

Principal Sum	\$10,000
Time Period for Loss	365 Days

Loss of:	Benefit: Percentage of Principal Sum
Life	100%
Both Hands or Feet, or Loss of Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand or One Foot and Entire Sight of One Eye	100%
One Hand or One Foot	50%
Entire Sight of One Eye	50%
Thumb and Index Finger of Same Hand	25%

Loss of a hand or foot means complete Severance through or above the wrist or ankle joint.

Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means.

Loss of a thumb and index finger means complete Severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand).

Severance means the complete separation and dismemberment of the part from the body.

Prescription Drug Information

Outpatient Prescription Drug Expense Benefit – Participating PMB Pharmacy

Benefits are available for outpatient Prescription Drugs, subject to the benefit amounts shown in the Schedule of Benefits, if any, for a Prescription Drug or medication when prescribed by a Physician on an Outpatient basis when dispensed by a CVS/Caremark pharmacy.

Prescription Medication must be obtained from a CVS/Caremark pharmacy

Present your Medical Identification card to the pharmacist, at the time of purchase. The pharmacy will bill TSS directly for your prescription. See the section titled, "How to File a Claim" for information on Prescription Medication Claims. A list of participating pharmacies can be viewed at: www.totalscholasticsolutions.com

Outpatient Prescription Drug Expense Benefit – Non-Participating PBM Pharmacy

We will pay benefits as shown in the Schedule of Benefits for a Prescription Drug or medication when prescribed by a Physician on an Outpatient basis. Present your Medical Identification card to the pharmacist at the time of purchase. The pharmacy will bill TSS directly for your prescription.

Prescription Insulin and Medically Necessary Covered Non-insulin Drug

Prescription insulin drugs and Medically Necessary covered Noninsulin Drugs are paid subject to the benefit amounts shown in the Schedule of Benefits. Present your Medical Identification card to the pharmacist at the time of purchase. **Noninsulin Drug** means a drug, including, but not limited to, a glucagon drug, glucose tablet or glucose gel, that does not contain insulin and is approved by the federal Food and Drug Administration to treat diabetes.

Description of Benefits

Hospital Room & Board Benefit: Hospital Room and Board expenses will include floor nursing while confined in a ward or semi-private room of a Hospital and other Hospital services inclusive of charges for professional service and with the exception of personal services of a non-medical nature; provided, however, that expenses do not exceed the Hospital's average charge for semiprivate room and board accommodation.

Hospital Miscellaneous Expense Benefit: Miscellaneous services include services and supplies such as: the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs (excluding take-home drugs) or medicines; therapeutic services; and supplies; and blood and blood transfusions. Miscellaneous services do not include charges for telephone, radio or television, extra beds or cots, meals for guests, take home items, or other convenience items.

Intensive Care Unit/Pediatric Care Benefit: This benefit will include expenses for confinement in an Intensive Care Unit/Pediatric Care Unit. This is in lieu of payment for the Hospital Room and Board charges for those days and includes nursing services.

Surgeon (in or outpatient) Benefits: This benefit includes expenses for a Physician for primary performance of a surgical procedure. Two or more surgical procedures through the same incision will be considered as one procedure. If an Injury or Sickness requires multiple surgical procedures through the same incision, We will pay only one benefit, the largest of the procedures performed. If multiple surgical procedures are performed during the same operative session, but through different incisions, We will pay for the most expensive procedure and 50% of Covered Expenses for the additional surgeries.

Assistant Surgeon Benefit: This benefit includes expenses, if in connection with an operation, the services of an Assistant Surgeon are required.

Anesthesia Benefit: This benefit includes pre-operative screening and administration of anesthesia during a surgical procedure whether on an Inpatient or Outpatient basis.

Pre-Admission Testing Benefit: We will pay benefits for charges for Pre-admission testing (Inpatient confinement must occur within 7 days of the testing).

Emergency Room Benefit: Means a trauma center or special area of a Hospital that is equipped and staffed to give people Emergency Treatment on an Outpatient basis. An Emergency Room is not a clinic or Physician's office.

Services including physician charges and related x-ray/laboratory interpretations will be paid under this benefit.

Ambulance Benefit: We will pay benefits when a Covered Person is confronted with a Life or Limb Threatening Emergency and requires the use of a community or Hospital ambulance for Emergency Treatment within the metropolitan area at the time of service. Ambulance service is transportation by a vehicle designed, equipped and used only to transport the sick and injured from home, the scene of the Accident or Emergency Treatment to a Hospital or between Hospitals.

Life or Limb Threatening Emergency means any event which the Covered Person believes threatens their life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Emergency Dental Expense Benefit: Emergency dental treatment due to sustaining an Injury to natural teeth. Only expenses for emergency dental treatment to Natural Teeth will be reimbursed.

Day Surgery Miscellaneous Benefit: Services and supplies such as the cost of the operating room; laboratory tests; X-ray examinations; anesthesia; drugs or medicine; therapeutic services; and supplies, on an Outpatient basis.

Physician Visit Benefit: Inpatient or Outpatient.

Consultant Physician Benefit: Benefits for a consultant or specialist deemed necessary and ordered by an attending Physician for the purpose of confirming or determining a diagnosis.

Nursing Services: Outpatient Charges for nursing services by a Nurse.

Hypodermic Needles/Injections Benefit: means hypodermic needles or syringes prescribed by a Physician, for the purpose of administering medications for a covered condition. This does not include immunizations for preventive care.

Wellness Medical Expense Benefit: Coverage is limited to the following expenses incurred subject to Exclusions. This benefit is not subject to Deductible or Coinsurance. In no event will the Company's maximum liability exceed the maximum stated in the Schedule of Benefits, as to expenses during any one period of individual coverage. Covered wellness expenses include: 1. Routine physical examinations: per Plan term which includes, routine physical examination, laboratory tests, x-rays and blood pressure screening; 2. Preventive medical attention includes: annual screening mammogram; sports exams; an annual cervical screening for women; a gynecological exam for women; routine screenings for ovarian cancer, including CA-125 monitoring, genetic testing, transvaginal, ultrasound, pelvic exam and other screening tests currently being evaluated by the

United States Food and Drug Administration or by the National Cancer Institute; Contraceptive Devices; Immunizations and vaccines. With respect to Immunizations and vaccines, coverage will include a twenty (20) minute consultation between the Covered Person and the Physician or provider authorized to administer such Immunizations or vaccines to the Covered Person.

Urgent Care Benefit: Means a walk-in clinic focused on the delivery of ambulatory care in a dedicated medical facility outside of a traditional Emergency Room. Urgent care centers primarily treat Injuries or Sickneses requiring immediate care, but not serious enough to require an Emergency Room visit.

Interscholastic Sports Activity Benefit: Means 1. Taking part in a regularly scheduled athletic game or competition; or practice session for an athletic team or club; 2. Traveling to or from such a game, competition or practice session provided he is traveling with the athletic team or club; and under the direct and immediate supervision of the athletic team or club; or an adult authorized by the athletic team or club; or 3. Traveling directly, without interruption between his home and a scheduled game, competition or practice session; In a vehicle which is designated or furnished by the athletic team or club; operated by a properly licensed, adult driver; or under the direct supervision of the athletic team or club; or in a vehicle other than that described in 3. when operated by a properly licensed driver; and travel time does not exceed 12 hour(s) each way. Travel time includes the time to or from home, a scheduled game, competition or practice session; before required attendance time; after the Covered Person is dismissed; and after the Covered Person completes extra duties assigned by the school.

Physiotherapy Expense Benefit: Means charges for physiotherapy if recommended by a Physician for the treatment of a specific Disablement and administered by a licensed Physician. Charges include treatment and office visits connected with such treatment when prescribed by a Physician, including diathermy, ultrasonic, whirlpool, heat treatments, adjustments, manipulation, acupuncture, massage or any form of Physical Therapy.

Durable Medical Equipment Expense Benefit: Includes the purchase or rental of Durable Medical Equipment. In no event shall we pay rental charges in excess of the purchase price. Any rental charges paid will be applied toward the cost of the purchase price if the equipment is purchased at a later date. We do not pay for the replacement of Durable Medical Equipment. **Durable Medical Equipment** includes oxygen and equipment, braces and appliances and medical equipment that: 1) is prescribed by the Physician who documents the necessity for the item including the expected duration of its use; 2) can withstand long-term repeated use without replacement; 3) is not useful in the absence of an Injury or Sickness; and 4) can be used in the home without medical supervision.

Diagnostic X-Ray Benefit & Laboratory Benefit: Diagnostic x -ray examinations and services and laboratory testing and services due to a covered loss when prescribed by a Physician.

CT Scan, PET Scan or MRI Benefit: Computed axial tomography scan (CT scan), positron emission tomography (PET scan) or magnetic resonance imaging (MRI) diagnostic services due to a Covered Loss, when prescribed by a Physician. Scans may include but are not limited to Medically Necessary radiology services, like coronary calcium scans.

Radiation/Chemotherapy Therapy Expense Benefit: For services and drugs used in antineoplastic therapy and the cost of its administration. Coverage is provided for any drug approved by the Federal Food and Drug Administration (FDA), regardless of whether the specific neoplasm for which the drug is being used as treatment is the specific neoplasm for which the drug was approved by the FDA, so long as: 1) the drug is ordered by a Physician for the treatment of a specific type of neoplasm; 2) the drug is approved by the FDA for use in

antineoplastic therapy; 3) the drug is used as part of an antineoplastic drug regimen; 4) current medical literature substantiates its efficacy, and recognized oncology organizations generally accept the treatment; and 5) the Physician has obtained informed consent from the patient or parent, guardian, or Power of Attorney for the treatment regimen that includes FDA-approved drugs for off-label indications.

Outpatient Prescription Drug Benefit: Means a Prescription Drug or medication when prescribed by a Physician on an Outpatient basis. **Prescription Drug** means a drug which: 1) Under Federal law may only be dispensed by written prescription; and 2) Is utilized for the specific purpose approved for general use by the Food and Drug Administration. The Prescription Drug must be dispensed for the Outpatient use by the Covered Person: 1) On or after the Covered Person's Effective Date; and 2) By a licensed pharmacy provider. Prescription Drugs also include Contraceptive Drugs and Contraceptive Devices.

Diabetes Treatment Expense Benefit: Means Medically Necessary diabetes equipment services and supplies for the treatment of diabetes, when recommended by a Physician. Such supplies include: blood glucose monitors, blood glucose monitors for the legally blind, data management systems, test strips for glucose monitors and visual reading, urine test strips, insulin, injection aids, cartridges for the legally blind, syringes, insulin pumps and appurtenances thereto, insulin infusion devices or oral agents for controlling blood sugar, Diabetic Ketoacidosis Devices, including any other Medically Necessary covered Diabetic Devices. We also cover charges for expenses incurred for diabetes self-management education.

Coverage for self-management education and education relating to diet shall be limited to Medically Necessary visits upon the diagnosis of diabetes, where a Physician diagnoses a significant change in the Covered Person's symptoms or conditions which necessitates changes in a patient's self-management or upon determination that reeducation or refresher education is necessary. Diabetes self-management education may be provided by a Physician, Physician assistant, or the Physician's office staff, as part of an office visit, or by a certified diabetes nurse educator, certified nutritionist, certified dietician, or registered dietician. Education may be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet includes Medically Necessary home visits.

Diabetic Device means a device, including but not limited to a blood glucose test strip, glucometer, continuous glucometer, lancet, lancing device or insulin syringe that is (A) a legend device or non-legend device, and (B) used to cure, diagnose, mitigate, prevent or treat diabetes or low blood sugar.

Diabetic Ketoacidosis Device means a device that is (A) a legend or non-legend device, and (B) used to screen for or prevent diabetic ketoacidosis.

Maternity and Pre-Natal Care Expense Benefit: Covered Expenses incurred before, during, and after delivery of a Newborn Infant, including Physician, Hospital, laboratory, and ultrasound services. Coverage for the Inpatient postpartum stay for the Covered Person and her Newborn Infant in a Hospital, will, at a minimum, be for the length of stay recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists in their guidelines for Perinatal Care.

Coverage for a length of stay shorter than the minimum period mentioned above may be permitted if the Covered Person's attending Physician confers with the mother and determines further Inpatient postpartum care is not necessary for the Covered Person or her Newborn Infant provided the following are met:

- 1) In the opinion of the Covered Person's attending Physician, the Newborn Infant meets the criteria for medical stability in the latest edition of "Guidelines for Perinatal Care" prepared by the Academy of Pediatrics and the American College of Obstetricians and Gynecologists that determine the appropriate

length of stay based upon the evaluation of: a) The antepartum, intrapartum, postpartum course of the mother and Newborn Infant; b) The gestational stage, birth weight, and clinical condition of the Newborn Infant; c) The demonstrated ability of the mother to care for the Newborn Infant after discharge; and d) The availability of post discharge follow up to verify the condition of the Newborn Infant after discharge; and

- 2) One (1) at-home post-delivery care visit is provided to the Covered Person at her residence by a Physician or Nurse performed no later than forty-eight (48) hours following discharge of the Covered Person and her Newborn Infant from the Hospital and an additional follow up within seven (7) days of discharge. Such services will be consistent with protocols and guidelines developed by the attending Physician or by national pediatric, obstetric and nursing professional organizations for these services and shall be provided by qualified health care personnel trained in postpartum maternal and newborn pediatric care. Coverage for the visits include but are not limited to: a) Parent education; b) Assistance in training in breast or bottle feeding; and c) Performance of any maternal or neonatal tests routinely performed during the usual course of Inpatient care for the Covered Person or Newborn Infant, including the collection of an adequate sample for the hereditary and metabolic newborn screening. (At the Covered Person's discretion, this visit may occur at the Physician's office.); d) Assessment of the home support system.

Alcohol and Drug Abuse Expense Benefit: Benefits will be payable for Inpatient and Outpatient services rendered by a Physician or psychologist; an advanced practice registered nurse; a clinical social worker; a social worker; a licensed marital and family therapist; a licensed alcohol and drug counselor; or a professional counselor. We will pay for such treatment as follows:

Inpatient Hospital Confinement: Means (i) a Hospital; or (ii) a Detoxification Facility for the treatment of Alcohol Abuse or Drug Abuse. The Confinement must be in a licensed or certified facility, including Hospitals.

Outpatient Alcohol and Drug Services: For the treatment of alcoholism, Alcohol Abuse, Drug Abuse, or drug dependency. Outpatient Treatment and Physician services include charges for services rendered in a Physician'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 Physician or a licensed psychologist who certifies that a Covered Person needs to continue such treatment.

Alcohol Abuse means a condition that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Drug Abuse means a condition that is characterized by a pattern of pathological use of a drug with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

Detoxification Facility means a facility that provides direct or indirect services to an acutely Intoxicated individual to fulfill the physical, social and emotional needs of the individual by: a) monitoring the amount of alcohol and other toxic agents in the body of the individual; b)

managing withdrawal symptoms; and c) motivating the individual to participate in the appropriate addictions treatment programs for Alcohol and Drug Abuse.

Mental or Nervous Conditions Expense Benefit: Benefits will be payable for Inpatient and Outpatient services rendered by a Physician or psychologist; an advanced practice registered nurse; a clinical social worker; a social worker; a licensed marital and family therapist; a licensed alcohol and drug counselor; or a professional counselor. For treatment of a Mental or Nervous Condition as follows:

Benefits for Inpatient Hospital Confinement: The confinement must be in a licensed or certified facility, including Hospitals.

Outpatient treatment of Mental and Nervous Conditions: The Mental and Nervous Condition must, in the professional judgment of healthcare providers, be treatable, and the treatment must be Medically Necessary. Outpatient treatment and Physician services include charges made by an Outpatient treatment department of a Hospital, Urgent Crisis Center, or community mental health facility, or charges for services rendered in a Physician's office. Treatment may be provided by any properly licensed Physician, psychologist or other provider as required by law. Treatment also includes intensive, home-based or evidence-based services designed to address specific Mental or Nervous Conditions in a child or adolescent. One visit per day.

Biologically Based Mental Sickness means a mental, nervous, or emotional disorder caused by a biological disorder of the brain which results in a clinically significant, psychological syndrome or pattern that substantially limits the functioning of the person with the Sickness. We will pay the covered percentage of the Covered Expenses incurred for treatment of biologically based mental Sickness, including: a) Schizophrenia; b) Schizoaffective disorder; c) bipolar affective disorder; d) major depressive disorder; e) specific obsessive-compulsive disorder; f) delusional disorders; g) obsessive compulsive disorders; h) binge eating, anorexia and bulimia; and i) panic disorder.

Coverage is provided for psychotropic drugs that are the most effective therapeutically indicated pharmaceutical treatment with the least probability of adverse side effects.

Coverage is also provided for Medically Necessary gender reassignment treatment. Covered services include:

- 1) Counseling by qualified mental health professional;
- 2) Hormone therapy, including monitoring of such therapy;
- 3) Gender reassignment surgery; and
- 4) Genital reconstructive surgery.

Emergency Medical Evacuation: If the local attending legally qualified Physician and the authorized travel assistance company determine that transportation to a Hospital or medical facility is Medically Necessary to treat an unforeseen Sickness or Injury which is acute or life threatening and adequate Medical Treatment is not available in the immediate area, the Transportation Expense incurred will be paid for the Usual and Customary Charges for transportation to the closest Hospital or medical facility capable of providing that treatment. If the Covered Person is traveling alone and will be hospitalized for more than 4 consecutive days and Emergency Evacuation is not imminent, benefits will be paid to transport one person, economy transportation, for a single visit to and from the Covered Person's bedside.

Return of Mortal Remains: In the event of the Covered Person's death, the expense incurred within 30 days from the date of the Covered Loss will be paid for minimally necessary casket or air tray, preparation and

transportation of their remains to their primary place of residence in the United States of America or to the place of burial.

Dental Services: includes Medically Necessary general anesthesia, nursing and related Hospital services provided in conjunction with Inpatient, Outpatient or one (1) day dental services if the following conditions are met: 1) The anesthesia, nursing and related hospital services are deemed Medically Necessary by the treating Dentist and the Covered Person's Physician; 2) The Covered Person is either (a) determined by a Dentist, in conjunction with a Physician 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 Covered Person who has a developmental disability, as determined by a Physician who specializes in primary care, that places the person at serious risk. The expense of such anesthesia, nursing and related hospital services shall be deemed a medical expense under the Policy and shall not be subject to any limits on dental benefits under the Policy.

Hypodermic Needles/Injections Benefit: means by reason of a covered Injury or Sickness, the Covered Person is prescribed hypodermic needles or syringes by a Physician, for the purpose of administering medications for a covered condition. This does not include immunizations for preventive care.

Early Intervention Services Benefit: means Medically Necessary services for the child of a Covered Person who is an Eligible Child on or after May 1st and not later than the first day of the next school year commencing July 1st. These benefits are available for Eligible Children who are not eligible for Connecticut special education and related services. Medically Necessary early intervention services may include but are not limited to: 1) Speech and language therapy; 2) Audiology services; 3) Vision services, including evaluation and assessment of visual functioning, referral for medical or other professional services, and communication skills training, orientation and mobility training, and additional training to activate visual motor abilities. 4) Occupational and Physical Therapy; 5) Nursing services, including assessment of health status for purposes of providing nursing care, provision of actual nursing care, administration of medications, treatments, and regimens prescribed by a Physician; 6) Psychological and social work services, including family training, counseling and home visits. This benefit is not subject to a coinsurance, copayment, deductible or other out-of-pocket expense.

Eligible Child(ren) means children

- A. (i) from birth to thirty-six months of age, who are not eligible for special education and related services, inclusive, and (ii) thirty-six months of age or older, who are receiving early intervention services and are eligible or being evaluated for participation in preschool services until such children are enrolled in such preschool services, and
- B. who need early intervention services because such children are:
 - I. Experiencing a significant developmental delay as measured by standardized diagnostic instruments and procedures, including informed clinical opinion in one or more of the following areas: Cognitive development; physical development, including vision or hearing; communication development; social or emotional development; or adaptive skills; or
 - II. Diagnosed as having physical or mental condition that has a high probability of resulting in developmental delay.

Autism Spectrum Disorder (ASD) Benefit: means the diagnosis and Medically necessary treatment of ASD, including care prescribed, provided or ordered for a Covered Person diagnosed with one (1) of the ASDs by a Physician, licensed psychologist or licensed clinical social worker.

Autism Spectrum Disorder (ASD) means a pervasive developmental disorder set forth in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders", including, but not limited to, Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder Not Otherwise Specified.

Diagnosis includes Medically Necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether a Covered Person has an ASD.

Treatments include: 1) Behavioral Therapy; 2) Prescription drugs, to the extent prescription drugs are a covered benefit for other diseases and conditions under such Policy, prescribed by a licensed physician, licensed Physician assistant or advanced practice registered nurse for the treatment of symptoms and comorbidities of ASD; 3) Direct psychiatric or consultative services provided by a licensed psychiatrist; 4) Direct psychological or consultative services provided by a licensed psychologist; 6) Physical Therapy provided by a licensed physical therapist; 7) Speech and language pathology services provided by a licensed speech and language pathologist; and 8) Occupational therapy provided by a licensed occupational therapist.

Behavioral Therapy means any interactive behavioral therapies derived from evidence-based research, including, but not limited to, Applied Behavior Analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed with an ASD, that are: (1) provided to children less than fifteen (15) years of age; and (2) provided or supervised by (a) a behavior analyst who is certified by the Behavior Analyst Certification Board, (b) a licensed Physician, or (c) a licensed psychologist. For the purposes of this benefit, Behavioral Therapy is "supervised by" such behavior analyst, licensed Physician or licensed psychologist when such supervision entails at least one (1) hour of face-to-face supervision of the Autism Services Provider by such behavior analyst, licensed Physician or licensed psychologist for each ten (10) hours of Behavioral Therapy provided by the supervised provider.

Applied Behavior Analysis means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior, to produce socially significant improvement in human behavior.

Autism Services Provider means any person, entity or group that provides treatment for ASD.

Long Term Antibiotic Therapy For The Treatment Of Lyme Disease Benefit: means long-term antibiotic therapy for a Covered Person with Lyme disease and ordered by a Physician after making a thorough evaluation of the Covered Person's symptoms, diagnostic test results or response to treatment. An experimental drug shall be covered as a long-term antibiotic therapy if it is approved for an indication by the United States Food and Drug Administration; provided, however, that a drug, including an experimental drug, shall be covered for an off-label use in the treatment of Lyme disease if the drug has been approved by the United States Food and Drug Administration.

Craniofacial And Temporomandibular Joint (TMJ) Disorders Benefits: means Medically Necessary orthodontic processes and appliances for the treatment of craniofacial disorders for Covered Persons 18 years of age and younger. Such processes and appliances must be prescribed by a craniofacial team recognized by the American Cleft Palate-Craniofacial Association. We will also pay benefits for TMJ disorders, both surgical and non-surgical. This benefit excludes cosmetic surgery.

Cancer Drugs Benefit: means Prescription Drugs for treatment of certain types of cancer and disabling or life-threatening chronic diseases for which the drug has not been approved by the Food and Drug Administration, if the drug is recognized as being medically appropriate for the treatment of a type of cancer for which it has been prescribed in one (1) of the following established reference compendia: 1) the United States Pharmacopoeia Drug Information; 2) the American Medical Association Drug Evaluations; 3) The American Society of Hospital Pharmacist's American Hospital Formulary Service Drug Information (AHFS-DI).

Surgical Removal Of Tumors; Treatment Of Leukemia; Prosthetic Devices Benefits: means surgical removal of tumors and the treatment of leukemia, including Outpatient chemotherapy, reconstructive surgery, costs of non-dental 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, and Outpatient chemotherapy following surgical procedures in connection with the treatment of tumors. Coverage will also be provided for one (1) wig, if prescribed by a Physician for a Covered Person who suffers hair loss as a result of chemotherapy.

We will pay benefits for the reasonable costs of reconstructive surgery on each breast on which a mastectomy has been performed, and reconstructive surgery on a non-diseased breast to produce a symmetrical appearance. Such benefits shall be subject to the same terms and conditions applicable to all other benefits under such policies. For the purposes of this subsection, reconstructive surgery includes, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

Mammography & Breast Ultrasound Benefit: diagnostic and screening mammograms that are at least equal to the following minimum requirements:

A. A baseline mammogram, which may be provided by breast tomosynthesis at the option of the Covered Person, for anyone who is:

- I. Thirty-five to thirty-nine years of age; or
- II. Younger than thirty-five years of age if the Covered Person is believed to be at increased risk for breast cancer due to:
 - a. A family history of breast cancer;
 - b. Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene variant that materially increases the Covered Person's risk for breast cancer;
 - c. Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest; or
 - d. Other indications as determined by the Covered Person's Physician, advanced practice registered nurse, Physician assistant, certified nurse midwife or other medical provider;and

B. A mammogram, which may be provided by breast tomosynthesis at the option of the Covered Person, every year for a Covered Person who is:

- I. Forty years of age or older; or
- II. Younger than forty years of age if the Covered Person is believed to be at increased risk for breast cancer due to:
 - a. A family history, or prior personal history, of breast cancer;
 - b. Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Covered Person's risk for breast cancer;

- c. Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest; or
- d. Other indications as determined by the Covered Person's Physician, advanced practice registered nurse, Physician assistant, certified nurse midwife or other medical provider.

We will provide additional benefits for:

- A. Comprehensive ultrasound screening diagnostic and screening ultrasounds of an entire breast or breasts if:
 - I. 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
 - II. The Covered Person is believed to be at increased risk for breast cancer due to:
 - a. A family history or prior personal history of breast cancer;
 - b. Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Covered Person's risk for breast cancer;
 - c. Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest; or
 - d. Other indications as determined by the Covered Person's Physician, Physician assistant or advanced practice registered nurse; or
 - III. such screening is recommended by a Covered Person's treating Physician for a Covered Person who:
 - a. is forty years of age or older,
 - b. has a family history or prior personal history of breast cancer, or
 - c. has a prior personal history of breast disease diagnosed through biopsy as benign; and advanced practice registered nurse, Physician assistant, certified nurse midwife or other medical provider;
- B. Magnetic Diagnostic and screening magnetic resonance imaging of an entire breast or breasts:
 - I. In accordance with guidelines established by the American Cancer Society for a Covered Person who is thirty-five years of age or older; or
 - II. If the Covered Person is younger than thirty-five years of age and believed to be at increased risk for breast cancer due to:
 - a. A family history, or prior personal history, of breast cancer;
 - b. Positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Covered Person's risk for breast cancer;
 - c. Prior treatment for a childhood cancer if the course of treatment for the childhood cancer included radiation therapy directed at the chest; or
 - d. Other indications as determined by the Covered Person's Physician, advanced practice registered nurse, Physician assistant, certified nurse midwife or other medical provider;
- C. Breast biopsies;
- D. Prophylactic mastectomies for a Covered Person who is believed to be at increased risk for breast cancer due to positive genetic testing for the harmful variant of breast cancer gene one, breast cancer gene two or any other gene that materially increases the Covered Person's risk for breast cancer; and
- E. Breast reconstructive surgery for an insured who has undergone:
 - I. A prophylactic mastectomy; or
 - II. A mastectomy as part of the Covered Person's course of treatment for breast cancer.

Prosthetic Devices Benefit: means repair or replacement of a Prosthetic Device as determined by the Covered Person's Physician or health care provider, unless such repair or replacement is necessitated by misuse or loss.

For purposes of this benefit, Prosthetic Device means an artificial limb device to replace, in whole or in part, an arm or a leg, including a device that contains a microprocessor if such microprocessor-equipped device is determined by the Covered Person's health care provider to be Medically Necessary. Prosthetic Device does not include a device that is designed exclusively for athletic purposes.

Prosthetic devices are not considered as Durable Medical Equipment under this Policy.

Neuropsychological Testing Benefit: means neuropsychological testing for a Covered Person who is diagnosed with cancer when ordered by a Physician to assess the extent of any cognitive or developmental delays in the Covered Person due to chemotherapy or radiation treatment.

Epidermolysis Bullosa Treatment Benefit: means wound-care supplies for the treatment of epidermolysis bullosa and are administered under the direction of a Physician.

Bone Marrow Testing Benefit: means human leukocyte antigen testing, also referred to as histocompatibility locus antigen testing, for A, B and DR antigens for utilization in bone marrow transplantation. The testing must be performed in a facility that is: a) accredited by the American Society for Histocompatibility and Immunogenetics, or its successor, and b) certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time. The testing is also limited to individuals who, at the time of such testing, complete and sign an informed consent form that also authorizes the results of the test to be used for participation in the National Marrow Donor Program. Coverage to a lifetime maximum benefit of one (1) testing is permitted.

Amino Acid Modified Preparation And Low Protein Modified Food Products Benefit: means treatment of inherited metabolic diseases, when prescribed by a Physician.

Inherited Metabolic Disease means a disease for which newborn screening is required under section 19a-55; and also includes cystic fibrosis.

Amino Acid Modified Preparation means a product intended for the dietary treatment of an inherited metabolic disease under the direction of a Physician.

Low Protein Modified Food Product means food that is specifically formulated to have less than one (1) gram of protein per serving and is intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease. Low Protein Modified Food Products do not include foods that are naturally low in protein.

Chiropractic Care Benefit: means Chiropractic Treatment of an Injury or Sickness performed by a licensed chiropractor. Chiropractic Treatment means manual treatment related to the musculoskeletal system that includes spinal adjustment and other joint and soft-tissue manipulation.

Pain Management Benefit: means treatment ordered by a pain management specialist, which may include all means Medically Necessary to make a diagnosis and develop a treatment plan including the use of necessary medications and procedures.

Hearing Aids Benefit: means hearing aid for a Covered Person, when prescribed or recommended by a Physician. Benefits include the related services of fitting, adjustments and supplies, including ear molds when

prescribed by a licensed audiologist or hearing instrument specialist. A Covered Person may choose a hearing aid that is priced higher than the benefit payable under this benefit and pay the difference between the hearing aid and the benefit payable.

Experimental Treatment Or Drug Benefit: means the use of any drug as experimental if such procedure, treatment or drug, for the Sickness or condition being treated, or for the diagnosis for which it is being prescribed, has successfully completed a phase III clinical trial of the federal Food and Drug Administration. A Covered Person who has been diagnosed with a condition that creates a life expectancy in that person of less than two (2) years and who has been denied an otherwise covered procedure, treatment or drug on the grounds that it is experimental may request an expedited appeal and may appeal a denial thereof to the Insurance Commissioner.

Mobile Field Hospital Benefit: means Medically Necessary isolation care and Emergency services provided by the state's mobile field Hospital.

Accidental Ingestion or Consumption of a Controlled Drug Benefit: Expenses for a medical Emergency arising from accidental ingestion or consumption of a Controlled Drug limited to: 1) Inpatient: While confined to a Hospital, up to a maximum of thirty (30) days in a calendar year. 2) Outpatient: Covered as Medically Necessary.

Controlled Drug means drugs which contain any quantity of a substance which has been designated as subject to the federal Controlled Substances Act, or which has been designated as a depressant or stimulant drug pursuant to federal food and drug laws, or which has been designated by the Commissioner of Consumer Protection pursuant to section 21a-243, as having a stimulant, depressant or hallucinogenic effect upon the higher functions of the central nervous system and as having a tendency to promote abuse or psychological or physiological dependence, or both. Such controlled drugs are classifiable as amphetamine-type, barbiturate-type, cannabis-type, cocaine-type, hallucinogenic, morphine-type and other stimulant and depressant drugs. Specifically excluded are alcohol, nicotine and caffeine.

Telehealth Services Benefit: If a Physician provides medical advice, diagnosis, care or treatment, We will pay benefits covered to treat a covered Accident or Sickness by means of for Telehealth, then those services shall be covered to the same extent as if the medical advice, diagnosis, care or treatment had been provided in person, if the services provided are Medically Necessary. Such medical advice, diagnosis, care or treatment shall be administered under the benefit that would apply had the service been received in person.

Telehealth means the mode of delivering health care or other health services via information and communication technologies to facilitate the diagnosis, consultation and treatment, education, care management and self-management of a Covered Person's physical, oral and mental health, and includes interaction between the insured at the originating site and the telehealth provider at a distant site, synchronous interactions, asynchronous store and forward transfers or remote patient monitoring, but does not include interaction through facsimile, texting or electronic mail unless the Physician or provider is In-Network or the Physician or provider enrolled in the Connecticut medical assistance program providing such health care or other health services to a Connecticut medical assistance program recipient.

Definitions

For the purposes of the Policy the capitalized terms used are defined as follows. This is a summary of definitions. For the complete list, please see the Policy on file with your school.

Accident means an unforeseeable and unexpected event which causes Injury to one or more Covered Persons independent of disease or bodily infirmity or any other cause.

Coinsurance means the percentage of Covered Expenses for which the Company is responsible for a specified covered service after the Deductible, if any, has been met.

Company means United States Fire Insurance Company. Also hereinafter referred to as We, Us and Our.

Contraceptive Devices include one (1) IUD every two (2) years (including removal), diaphragms, and cervical caps.

Contraceptive Drugs include oral contraceptives (combined estrogen and progestin and progestin-only), NuvaRing, Depo Vera and Ortho Evra.

Cosmetic Surgery means the surgical alteration of tissue primarily for the improvement of appearance rather than to improve or restore bodily functions.

Covered Accident means an Accident that occurs while coverage is in force for a Covered Person and results in a Covered Loss for which benefits are payable.

Covered Expense means charges:

- a) Not in excess of Usual, Reasonable and Customary charge;
- b) Not in excess of the maximum benefit amount payable per service as shown in the Schedule;
- c) Made for medical services and supplies not excluded under the Policy;
- d) Made for services and supplies which are Medically Necessary; and
- e) Made for medical services specifically included in the Schedule.

Covered Expense must be incurred by the Covered Person while the Policy is in force.

Covered Person means a person eligible for coverage as identified in the Schedule of Benefits for whom proper premium payment has been made, and who is therefore insured under the Policy.

Custodial Care means any care that is provided to a Covered Person who is disabled and needs help to support the essential Activities of Daily Living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of Activities of Daily Living on His own.

Deductible means the dollar amount of Covered Expense which must be incurred and paid by the Covered Person before benefits are payable under the Policy. It applies separately to each Covered Person.

Dentist means a legally licensed doctor of dental surgery; dental medicine or dental science. A dental hygienist who works within the scope of his/her license, under the supervision of a Dentist, is a covered practitioner.

Emergency/Emergency Treatment means a Sickness or Injury for which the Covered Person seeks immediate

medical treatment at an available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care a prudent lay-person possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would cause:

- His life or health would be in serious jeopardy, or, with respect to a pregnant woman, serious jeopardy to the health of the woman or her unborn child;
- His bodily functions would be seriously impaired; or
- A body organ or part would be seriously damaged.

Hospital means an institution licensed, accredited or certified by the State that:

- 1) Operates as a Hospital pursuant to law for the care, treatment and providing Inpatient services for sick or injured persons;
- 2) Is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- 3) Provides 24-hour nursing service by a Nurse on duty or call;
- 4) Has a staff of one or more licensed Physicians available at all times;
- 5) Provides organized facilities for diagnosis, treatment and surgery, either
 - a. on its premises; or
 - b. in facilities available to it, on a pre-arranged basis;
- 6) Is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
- 7) Is not a place for drug addicts, alcoholics or the aged.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

We will not deny a claim for services solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability, and the Hospital is accredited by any one of the following:

- 1) the Joint Commission of Accreditation of Hospitals; or
- 2) the American Osteopathic Association; or
- 3) the Commission on the Accreditation of Rehabilitative Facilities.

In addition, We will not deny a claim for a Skilled Nursing Facility if it meets the definition of such a facility and is a Covered Expense under the Policy.

Hospital does not include a place, special ward, floor or other accommodation used for: custodial or educational care; rest, the aged; a nursing home or an institution mainly rendering treatment or services for mental illness or substance abuse, except as specifically stated.

Immediate Family means a Covered Person's parent (includes Step-parent), brother, sister, grandparents. A Member of the Immediate Family includes an individual who normally lives in the Covered Person's household.

Immunizations include: flu shot, tetanus, diphtheria, pertussis, Tdap, Haemophilus influenza type b, hepatitis A, hepatitis B, HPV, measles-mumps-rubella, pneumonia, varicella, pneumococcal, rotavirus, meningococcal, COVID-19; only as recommended by the U.S. Centers for Disease Control and Prevention.

Injury means bodily harm resulting, directly and independently of disease or bodily infirmity, from an Accident. The Accident would occur after the effective date of a Covered Person's coverage under the Policy and while the Policy is in force. All injuries to the same Covered Person sustained in one Accident, including all related conditions and recurring symptoms of the Injuries will be considered one Injury.

Intensive Care Unit/Pediatric Care Unit means a cardiac care unit or other unit or area of a Hospital which meets the required standards of the Joint Commission on Accreditation of Hospitals for Special Care Units.

Inpatient means a Covered Person who incurs medical expenses for at least one day's room and board from a Hospital; or more than 23 hours in an Observation Unit.

Maximum Benefit means the largest total amount of Covered Expenses that the Company will pay for the Covered Person as shown in the Schedule of Benefits.

Medically Necessary means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an Injury or Sickness and that are: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate, in terms of type, frequency, extent, site and duration and considered effective for the patient's Injury or Sickness; and (3) 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 Injury. For the purposes of this definition, "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.

Mental or Nervous Disorder means mental disorders, as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. This definition does not include mental retardation, learning disorders, motor skills disorders, communication disorders, caffeine-related disorders, relational problems, and additional conditions that may be a focus of clinical attention, that are not otherwise defined as Mental or Nervous Disorders in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. May also be known as a **Mental or Nervous Condition**.

Natural Teeth means the major portion of the individual tooth which is present, regardless of filings and caps; and is not carious, abscessed, or defective.

Nurse means either a professional, licensed, graduate registered nurse (R.N.) or a professional, licensed practical nurse (L.P.N.).

Physician means a person who is a qualified practitioner of medicine. As such, he or she must be acting within the scope of his/her license under the laws in the state in which he or she practices and providing only those medical services which are within the scope of his/her license or certificate. It does not include a Covered Person, or a Covered Person's Immediate Family.

Physical Therapy means any form of the following administered by a Physician: 1) physical or mechanical therapy; 2) diathermy, 3) ultra-sonic therapy; 4) heat treatment in any form; or 5) manipulation or massage.

Prescription Drugs means a drug which: (1) under Federal law may only be dispensed by written prescription; and (2) is utilized for the specific purpose approved for general use by the Food and Drug Administration. The Prescription Drug must be dispensed for the Outpatient use by the Covered Person: 1) On or after the Covered Person's Effective Date; and 2) By a licensed pharmacy provider. Prescription Drugs also includes Contraceptive Drugs and Contraceptive Devices.

Skilled Nursing Facility means a facility that provides skilled nursing 24 hours a day, seven (7) days a week, under the supervision of a Nurse, and/or skilled rehabilitative services at least five (5) days per week. The emphasis is on skilled nursing care, with restorative, physical, occupational, and other therapies available. A Skilled Nursing Facility provides services that cannot be efficiently or effectively rendered at home or in an intermediate care facility. The service provided must be directed towards the patient achieving independence in activities of daily living, improving the patient's condition, and facilitating discharge.

Sickness means illness or disease which requires treatment by a Physician while covered by the Policy. The Sickness would occur after the effective date of a Covered Person's coverage under the Policy and while the Policy is in force. All related conditions and recurrent symptoms of the same or a similar condition will be considered the same Sickness.

Urgent Crisis Center means a center licensed by the Department of Children and Families that is dedicated to treating children's urgent mental or behavioral health needs.

Usual, Reasonable and Customary charges, fees or Expenses as used in the Policy to describe expense will be considered to mean the percentile of the payment system in effect at Policy issue as shown on the Schedule of Benefits.

We, Our, Us means United States Fire Insurance Company underwriting this Insurance.

Exclusions

The Policy does not cover any loss resulting from any of the following unless otherwise covered under the Policy by Additional Benefits:

1. War or any act of war, declared or undeclared;
2. Charges which are in excess of Usual, Reasonable and Customary charges, if applicable;
3. Charges that are not Medically Necessary;
4. Charges provided at no cost to the Covered Person;
5. Charges incurred for Surgery or treatments which are, experimental, or for research purposes, unless specifically covered by Policy;
6. Elective or Cosmetic surgery and Elective Treatment or treatment for congenital anomalies (unless specifically covered by the Policy), except for reconstructive surgery on a diseased or injured part of the body (Correction of a deviated nasal septum is considered Cosmetic Surgery unless it results from a covered Injury or Sickness);
7. Travel or flight in or on any vehicle for aerial navigation, including boarding or alighting from:
 - a) While riding as a passenger in any aircraft not intended or licensed for the transportation of passengers; or
 - b) While being used for any test or experimental purpose; or
 - c) While piloting, operating, learning to operate or serving as a member of the crew thereof; or
 - d) While traveling in any such aircraft or device which is owned or leased by or on behalf of the Policyholder of any subsidiary or affiliate of the Policyholder, or by the Covered Person or any member of his household.
 - e) A space-craft or any craft designed for navigation above or beyond the earth's atmosphere. Except as a fare paying passenger on a regularly scheduled commercial airline.

8. Services rendered for detection and correction by manual or mechanical means (including x-rays incidental thereto) of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column, unless specifically covered by Policy;
9. Services or treatment rendered by a Physician, Nurse or any other person who is employed or retained by the Policyholder; or an Immediate Family member of the Covered Person;
10. Any Covered Loss paid under Workers' Compensation, Employer's liability laws or similar occupational benefits or while engaging in an occupation for monetary gain from sources other than the Policyholder;
11. Eyeglasses, contact lenses, or examinations for prescriptions;
12. Rest cures or Custodial Care;
13. Dental care or treatment other than care of sound, natural teeth and gums required on account of Injury resulting from an Accident;
14. Commission or attempt to commit an assault or felony, or that occurs while being engaged in an illegal act;
15. Voluntary, active Participation in a Riot or insurrection; "**Participation**" means promoting, inciting, conspiring to promote or incite, aiding, abetting, and all forms of taking part in, but does not include actions taken in defense of public or private property, or actions taken in defense of the person of the insured, if such actions of defense are not taken against persons seeking to maintain or restore law and order including, but not limited to, police officers and firefighters. "**Riot**" means all forms of public violence, disorder, or disturbance of the public peace, by three or more persons assembled together, whether or not acting with a common intent and whether or not damage to persons or property or unlawful act or acts is the intent or consequence of such disorder;
16. Medical expenses resulting from a motor vehicle accident in excess of that which is payable under any other valid and collectible insurance.

Non-Insurance Assistance Services

Non-insurance Assistance services are provided by TSS Assist and not affiliated with the insurance provided by United States Fire Insurance Company. An outline of the assistance services appears below.

Medical Emergency Services

- Worldwide, 24-hour medical location service
- Medical case monitoring, arrange communication between patient, family, physicians, employer, consulate, etc.
- Medical transportation arrangements –Emergency Evacuation/Return of Mortal Remains
- Emergency message service for medical situations

Legal Assistance

- Worldwide, 24-hour contact for non-criminal legal emergencies
- Legal referral to help you locate a consular official or attorney

Travel Assistance

- Help with lost passports, tickets and documents

TSS Assist

- U.S.: 1 (800) 730-2417
- E-mail for emergencies to assist@tssassist.com

Claim Procedures for Accident and Sickness Benefits

In the event of Accident or Sickness, students should:

1. Report to the Student Health Service or Infirmary for treatment or referral, or when not in school, to the nearest Physician or Hospital.
2. Provide the ID card to the Physician or at the Hospital.
3. If there is an Injury or Accident, submit a Medical Accident Questionnaire to TSS.
4. In the event the provider does not submit the claim, secure a Company claim form from the Student Health Services or from the address below, fill out the form completely, attach all medical and hospital bills and statements and submit via one of the options below.
5. File claim within 30 days of Injury or first treatment for a Sickness. Bills should be received by the Company within 90 days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

Submit all Claims or Inquiries to:

Total Scholastic Solutions

Mail: TSS Administrative Services
PO Box 211008
Eagan, MN 55121
USA

Web: www.totalscholasticsolutions.com
E-mail: claimsassist@tssassist.com
Fax: 1-949-271-2330

Pre-Notification

TSS Assist should be notified of all Hospital Confinements prior to admission.

1. PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS: The patient, Physician or Hospital should telephone 1-800-730-2417 at least five working days prior to the planned admission.

2. NOTIFICATION OF MEDICAL EMERGENCY ADMISSIONS: The patient, patient's representative, Physician or Hospital should telephone 1-800-730-2417 within two working days of the admission to provide notification of any admission due to Medical Emergency.

IMPORTANT: Failure to follow the notification procedures will not affect benefits otherwise payable under the Policy and no penalties will be applied; however, pre-notification is not a guarantee that benefits will be paid.

Medical and Prescription Medication Claims

To file your claim, submit it online at www.totalscholasticsolutions.com. Log into the Member Area and select Submit Claim, and then follow the instructions to complete the online claim form. If you are unable to submit your claim electronically, you can mail or fax your completed claim form and copies of supporting documentation. After submitting the claim, you will receive a claim reference number and an electronic receipt for the claim will be sent to you by email.

How You Can Reach Us

Customer Service, Pre-Notification, and Help Locating a Provider (24/7)

Within the United States or Canada: 1-800-730-2417

Email: assist@tssassist.com

Website: www.totalscholasticsolutions.com

If you have questions, or in the event you remain dissatisfied and wish to make a complaint, you can do so by contacting the Plan Administrator at:

Clifford Allen Associates, Ltd.

PO Box 23615

Hilton Head Island, SC 29925

(888) 342-2224

info@shipsignup.com

Plan Underwriting Information

Plan is Underwritten by: United States Fire Insurance Company. C&F and Crum & Forster are registered trademarks of United States Fire Insurance Company. This is a brief summary of coverage and is subject to the terms, conditions, limitations and exclusions of the Policy. Please see the Policy on file with the school for complete details of your coverage.

This insurance is not subject to, and does not provide certain insurance benefits required by the United States' Patient Protection and Affordable Care Act ("PPACA"). PPACA requires certain US citizens or US residents to obtain PPACA compliant health insurance, or "minimum essential coverage." Tax penalties may be imposed on U.S. residents or citizens who do not maintain minimum essential coverage, and in some cases, certain individuals may be deemed to have minimum essential coverage under PPACA even if their insurance coverage does not provide all of the benefits required by PPACA. You should consult your attorney or tax professional to determine whether the Policy meets any obligations you may have under PPACA.

Complaints

In the event that you remain dissatisfied and wish to make a complaint you can do so to the Complaints team at 888-342-2224.

THIS IS LIMITED BENEFIT COVERAGE. READ THE POLICY CAREFULLY. THE POLICY IS NOT RENEWABLE. THIS IS NOT A SUBSTITUTE FOR HOSPITAL OR MEDICAL EXPENSE INSURANCE.

The insurance described in this document provides limited benefits. Limited benefits are insurance products with reduced benefits intended to supplement comprehensive health insurance plans. This insurance is not an alternative to comprehensive coverage. It does not provide major medical or comprehensive medical coverage and is not designed to replace major medical insurance. Further, this insurance is not minimum essential benefits as set forth under the Patient Protection and Affordable Care Act.

This is a brief description of coverage provided under form number BA-51000-P-CT Rev.7/24 and is subject to the terms, conditions, limitations and exclusions of the Policy. Please see the Policy and certificate for complete details. Coverage may vary or may not be available in all states. Insurance is underwritten by United States Fire Insurance Company, with its principal place of business at 5 Christopher Way, Eatontown NJ.

Please keep this brochure as a general summary of the important features of the plan. It is not a contract of insurance. This plan includes both insurance and non-insurance benefits. The terms and conditions of the accident and sickness coverage are set forth in the plan issued to your school. For a detailed plan description, exclusions, and limitations, please view the plan on file with your school. The issued Policy contains a complete description of reductions, limitations, exclusions, definitions and termination provisions. If there is any conflict between this brochure and the Policy, the Policy shall govern in all cases. Insurance is underwritten by United States Fire Insurance Company with its principal place of business at 5 Christopher Way, Eatontown, NJ.

Data Protection

Please note that sensitive health and other information that you provide may be used by us, our representatives, the insurers and industry governing bodies and regulators to process your insurance, handle claims and prevent fraud. This may involve transferring information to other countries (some of which may have limited, or no data protection laws). We have taken steps to ensure your information is held securely.

Where sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use as set out above.

Information we hold will not be shared with third parties for marketing purposes. You have the right to access your personal records.

INTERNAL AND EXTERNAL APPEALS PROCESS

DEFINITIONS

Adverse Determination means:

1. A determination by Us that, based upon the information provided, a request for benefits under the Policy/Certificate does not meet the Company's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, or is determined to be experimental, and the requested benefit is denied, reduced, in whole or in part, or terminated;
2. A denial, reduction, in whole or in part, or termination based on the Company's determination that the individual was not eligible for coverage under the Policy/Certificate as a Covered Person;
3. Any prospective or retrospective review determination that denies, reduces, in whole or in part, or terminates a request for benefits under the Policy/Certificate; or
4. A rescission of coverage.

Authorized Representative means:

1. A person to whom a Covered Person has given express written consent to represent the Covered Person;
2. A person authorized by law to provide substituted consent for a Covered Person;
3. A Covered Person's family member or health care provider when the Covered Person is unable to provide consent; or
4. In the case of an Urgent Care Request, a health care professional with knowledge of the Covered Person's medical condition.

Final Adverse Determination means an Adverse Determination involving a Covered Expense that has been upheld by the Company, at the completion of the Company's internal appeal process or an Adverse Determination for which the internal appeals process has been deemed exhausted in accordance with this notice.

Prospective Review means Utilization Review performed: (1) prior to an admission or the provision of a health care service or course of treatment; and (2) in accordance with the Company's requirement that the service be approved, in whole or in part, prior to its provision.

Retrospective Adverse Determination is a determination for which Utilization Review was initiated after health care services have been provided. Retrospective Adverse Determination does not mean a pre-authorization denial or a determination involving continued or extended health care services or additional services for a patient undergoing a course of continued treatment.

Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

1. Could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function; or
2. In the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

Utilization Review means a set of formal techniques designed to monitor the use of or evaluate the Medical Necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities. Techniques may include ambulatory review, Prospective Review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

INTERNAL APPEAL PROCESS

Within 180 days after receipt of a notice of an Adverse Determination, a Covered Person or an Authorized Representative may submit a written request for an Internal Review of an Adverse Determination. Upon receipt of the request for an Internal Review, the Company shall provide the Covered Person with the name, address and telephone of the employee or department designated to coordinate the Internal Review for the Company.

With respect to an Adverse Determination involving Utilization Review, the Company shall designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case which is the subject of the Adverse Determination. The clinical peer(s) shall not have been involved in the initial Adverse Determination.

Within [30 -60] business days after receipt of the grievance, the Company shall provide notice that the Covered Person or Authorized Representative is entitled to:

1. Submit written comments, documents, records, and other material relating to the request for benefits to be considered when conducting the Internal Review; and
2. Receive from the Company, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Covered Person's request for benefits.

Prior to issuing or providing a notice of Final Adverse Determination, the Company shall provide, free of charge and as soon as possible:

1. Any new or additional evidence considered by the Company in connection with the grievance;
2. Any new or additional rationale upon which the decision was based.

The Covered Person or Authorized Representative shall have ten (10) calendar days to respond to any new or additional evidence or rationale.

The company shall issue a Final Adverse Decision in writing or electronically to the Covered Person or the Authorized Representative as follows:

1. For a Prospective Review, the notice shall be made no later than thirty (30) days after the Company's receipt of the grievance.

2. For a Retrospective Review, the notice shall be made no later than sixty (60) days after the Company's receipt of the grievance.

Time periods shall be calculated based on the date the Company receives the request for the Internal Review, without regard to whether all of the information necessary to make the determination accompanies the request.

The written notice of Final Adverse Determination for the Internal Review shall include:

1. The titles and qualifying credentials of the reviewers participating in the Internal Review;
2. Information sufficient to identify the claim involved in the grievance, including the following:
 - a. the date of service;
 - b. the name health care provider; and
 - c. the claim amount;
3. A statement that the diagnosis code and treatment code and their corresponding meanings shall be provided to the Covered Person or the Authorized Representative, upon request;
4. For an Internal Review decision that upholds the Company's original Adverse Determination:
 - a. the specific reason(s) for the Final Adverse Determination, including the denial code and its corresponding meaning, as well as a description of the Company's standard, if any, that was used in reaching the denial;
 - b. reference to the specific Policy/Certificate provisions upon which the determination is based;
 - c. a statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the Covered Person's benefit request;
 - d. if applicable, a statement that the Company relied upon a specific internal rule, guideline, protocol, or similar criterion and that a copy will be provided free of charge upon request;
 - e. if the Final Adverse Determination is based on a medical necessity or and Experimental/Investigational treatment or similar exclusion or limitation, a statement that an explanation will be provided to the Covered Person free of charge upon request;
 - f. instructions for requesting: (i) a copy of the rule, guideline, protocol or other similar criterion relied upon to make the Final Adverse Determination; and (ii) the written statement of the scientific or clinical rationale for the determination;
5. A description of the procedures for obtaining an external independent review of the Final Adverse Determination pursuant to the state's external review legislation;
6. Copies of the state's external appeal instructions and application form; and
7. The Covered Person's right to bring a civil action in a court of competent jurisdiction.
8. A statement disclosing the covered person's right to contact the Connecticut commissioner's office or the Office of the Healthcare Advocate at any time, along with contact information.

Expedited Internal Review (EIR) of an Adverse Determination

The Covered Person or an Authorized Representative may submit an oral or written request for an Expedited Internal Review (EIR) of an Adverse Determination:

1. involving Urgent Care Requests; and
2. related to a concurrent review Urgent Care Request involving an admission, availability of care, continued stay or health care service for a Covered Person who has received emergency services, but has not been discharged from a facility.

All necessary information, including the Company's decision, shall be transmitted to the Covered Person or an Authorized Representative via telephone, facsimile or the most expeditious method available. The Covered Person or the Authorized Representative shall be notified of the EIR decision no more than seventy-two (72) hours after the Company's receipt of the EIR request.

If the EIR request is related to a concurrent review Urgent Care Request, benefits for the service will continue until the Covered Person has been notified of the final determination.

At the same time a Covered Person or an Authorized Representative files an EIR request, the Covered Person or the Authorized Representative may file:

1. An Expedited External Review (EER) request if the Covered Person has a medical condition where the timeframe for completion of an EIR would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or
2. An Expedited Experimental/Investigational Treatment External Review (EEIER) request if the Adverse Determination involves a denial of coverage based on the a determination that the recommended or requested service or treatment is Experimental/Investigational and the Covered Person's treating Physician certifies in writing that the recommended or requested service or treatment would be significantly less effective if not promptly initiated.

The notice of Final Adverse Determination may be provided orally, in writing, or electronically.

EXTERNAL APPEALS

A Covered Person or an Authorized Representative may file a request for an external review or an EER of an Adverse Determination or a Final Adverse Determination. All requests for external review or EER shall be made in writing to the commissioner. The commissioner may prescribe the form and content of such requests.

The Company will pay the independent review organization for the cost of conducting the review.

An external review decision, whether such review is a standard external review or an EER, will be binding on the Company or a self-insured governmental plan and the Covered Person, except to the extent We or the Covered Person has other remedies available under federal or state law. A Covered Person or an Authorized Representative shall not file a subsequent request for an external review or an EER that involves the same Adverse Determination or Final Adverse Determination for which the Covered Person or the Authorized Representative already received an external review decision or an EER decision.

A Covered Person or the Authorized Representative shall not file a request for an external review or an EER until the Covered Person or the Authorized Representative has exhausted the Company's internal grievance process.

The Company may waive its internal grievance process and the requirement for a Covered Person to exhaust such process prior to filing a request for an external review or an EER.

At the same time We send to a Covered Person or an Authorized Representative a written notice of an Adverse Determination or a Final Adverse Determination issued, We shall include a written disclosure to the Covered Person and, if applicable, the Authorized Representative of the Covered Person's right to request an external review.

The written notice shall include:

1. The following statement or a statement in substantially similar language: "We have denied your request for benefit approval for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with the Company by submitting a request for external review to the office of the Insurance Commissioner, if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested.";

2. For a notice related to an Adverse Determination, a statement informing the Covered Person that:

(1) If the Covered Person has a medical condition for which the time period for completion of an EIR of a grievance involving an Adverse Determination would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function, the Covered Person or the Authorized Representative may file a request for an EER, or file a request for an EER if the Adverse Determination involves a denial of coverage based on a determination that the recommended or requested health care service or treatment is Experimental/Investigational and the Covered Person's treating Physician certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; and

(2) Such request for EER may be filed at the same time the Covered Person or the Authorized Representative files a request for an EIR of a grievance involving an Adverse Determination, except that the independent review organization assigned to conduct the EER shall determine whether the Covered Person shall be required to complete the EIR of the grievance prior to conducting the EER;

3. For a notice related to a Final Adverse Determination, a statement informing the Covered Person that:

(1) If the Covered Person has a medical condition for which the time period for completion of an external review would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function, the Covered Person or the Authorized Representative may file a request for an EER; or

(2) If the Final Adverse Determination concerns:

(l) an admission, availability of care, continued stay or health care

service for which the Covered Person received emergency services but has not been discharged from a facility, the Covered Person or the Authorized Representative may file a request for an EER, or

(II) a denial of coverage based on a determination that the recommended or requested health care service or treatment is Experimental/Investigational and the Covered Person's treating Physician certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated, the Covered Person or the Authorized Representative may file a request for an EER.

4. A copy of the description of both the standard and EER procedures, highlighting the provisions in the external review procedures that give the Covered Person or the Authorized Representative the opportunity to submit additional information and including any forms used to process an external review or an EER;

As part of any forms provided, an authorization form or other document approved by the commissioner, by which the Covered Person shall authorize the Company and the treating Physician to release, transfer or otherwise divulge, in accordance with sections 38a-975 to 38a-999a, inclusive, the Covered Person's protected health information including medical records for purposes of conducting an external review or an EER;

5. A statement that the Covered Person or the Authorized Representative may request, free of charge, copies of all documents, communications, information and evidence regarding the Adverse Determination or the Final Adverse Determination that were not previously provided to the Covered Person or the Authorized Representative.

A Covered Person or the Authorized Representative may file a request for an EER of an Adverse Determination or a Final Adverse Determination with the commissioner, except that an EER shall not be provided for a retrospective review request of an Adverse Determination or a Final Adverse Determination.

Such request may be filed at the time the Covered Person receives:

1. An Adverse Determination, if:

(i) (I) The Covered Person has a medical condition for which the time period for completion of an EIR of the Adverse Determination would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function; or

(II) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is Experimental/Investigational and the Covered Person's treating Physician certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated; and

(ii) The Covered Person or the Authorized Representative has filed a request for an expedited internal review of the Adverse Determination; or

2. A Final Adverse Determination if:

(i) The Covered Person has a medical condition where the time period for completion of a standard external review would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function;

(ii) The Final Adverse Determination concerns an admission, availability of care, continued stay or health care

service for which the Covered Person received emergency services but has not been discharged from a facility;
or

(iii) The denial of coverage is based on a determination that the recommended or requested health care service or treatment is Experimental/Investigational and the Covered Person's treating Physician certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.

Such Covered Person or Authorized Representative shall not be required to file a request for an external review prior to, or at the same time as, the filing of a request for an EER and shall not be precluded from filing a request for an external review:

Not later than one hundred twenty (120) calendar days after a Covered Person or the Authorized Representative receives a notice of an Adverse Determination or a Final Adverse Determination, the Covered Person or the Authorized Representative may file a request for an external review or an EER with the commissioner.

Not later than one (1) business day after the commissioner receives a request that is complete, the commissioner shall:

(i) Send a copy of such request to the Company that issued the Adverse Determination or the Final Adverse Determination that is the subject of the request; and

(ii) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner to conduct the review and notify the Company of the name of the assigned independent review organization. Such assignment shall be done on a random basis among those approved independent review organizations qualified to conduct the particular review based on the nature of the health care service that is the subject of the Adverse Determination or the Final Adverse Determination and other circumstances, including conflict of interest concerns.

Not later than five (5) business days after We receive the copy of an external review request or one (1) calendar day after the We receive the copy of an EER request, from the commissioner, We shall complete a preliminary review of the request to determine whether:

1. The individual is or was a Covered Person under the plan at the time the health care service was requested or, in the case of an external review of a retrospective review request, was a Covered Person in the plan at the time the health care service was provided;
2. The health care service that is the subject of the Adverse Determination or the Final Adverse Determination is a covered service under the Covered Person's plan but for the Company's determination that the health care service is not covered because the health care service does not meet the the Company's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness;
3. If the health care service or treatment is Experimental/Investigational:
 - (i) Is a covered benefit under the Covered Person's plan but for the Company's determination that the service or treatment is Experimental/Investigational for a particular medical condition;

- (ii) Is not explicitly listed as an excluded benefit under the Covered Person's plan;
- (iii) The Covered Person's treating Physician has certified that one of the following situations is applicable:
 - (I) Standard health care services or treatments have not been effective in improving the medical condition of the Covered Person;
 - (II) Standard health care services or treatments are not medically appropriate for the Covered Person; or
 - (III) There is no available standard health care service or treatment covered under the plan that is more beneficial than the recommended or requested health care service or treatment; and the Covered Person's treating Physician has recommended a health care service or treatment that the Physician certifies, in writing, is likely to be more beneficial to the Covered Person, in the Physician's opinion, than any available standard health care services or treatments; or is a licensed, board certified or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the Covered Person's condition and has certified in writing that scientifically valid studies using accepted protocols demonstrate that the health care service or treatment requested by the Covered Person that is the subject of the Adverse Determination or the Final Adverse Determination is likely to be more beneficial to the Covered Person than any available standard health care services or treatments;
- 4. The Covered Person has exhausted the Company's internal grievance process or the Covered Person or the Authorized Representative has filed a request for an EER as provided; and
- 5. The Covered Person has provided all the information and forms required to process an external review or an EER.

Not later than one (1) business day after the preliminary review of an external review request or the day the preliminary review of an EER request is completed, the Company shall notify the commissioner, the Covered Person and, if applicable, the Authorized Representative in writing whether the request for an external review or an EER is complete and eligible for such review. The commissioner may specify the form for the Company's notice of initial determination under and any supporting information required to be included in the notice.

If the external review or the EER is accepted, We shall notify the commissioner, the Covered Person and, if applicable, the Authorized Representative in writing of the request's eligibility and acceptance for external review or EER. For an external review, We shall include in such notice: (i) a statement that the Covered Person or the Authorized Representative may submit, not later than five (5) business days after the Covered Person or the Authorized Representative, as applicable, received such notice, additional information in writing to the assigned independent review organization that such organization shall consider when conducting the external review, and (ii) where and how such additional information is to be submitted. If additional information is submitted later than five (5) business days after the Covered Person or the Authorized Representative, as applicable, received such notice, the independent review organization may, but shall not be required to, accept and consider such additional information.

If the request:

- (i) Is not complete, We shall notify the commissioner and the Covered Person and, if applicable, the Authorized Representative in writing and include in the notice what information or materials are needed to perfect the request; or

(ii) Is not eligible for external review or EER, We shall notify the commissioner, the Covered Person and, if applicable, the Authorized Representative in writing and include in the notice the reasons for its ineligibility.

The notice of initial determination shall include a statement informing the Covered Person and, if applicable, the Authorized Representative that the Company's initial determination that the request for an external review or an EER is ineligible for review may be appealed to the commissioner.

Notwithstanding the Company's initial determination that a request for an external review or an EER is ineligible for review, the commissioner may determine, pursuant to the terms of the Covered Person's plan, that such request is eligible for such review and assign an independent review organization to conduct such review.

Not later than five (5) business days for an external review or one (1) calendar day for an EER, after the Company accepts the external review or EER, The Company or its designee utilization review company shall provide to the assigned independent review organization the documents and any information the Company's or its utilization review company considered in making the Adverse Determination or the Final Adverse Determination.

The failure of the Company or its designee utilization review company to provide the documents and information within the time specified shall not delay the conducting of the review.

If the Company or its designee utilization review company fails to provide the documents and information within the time period specified, the independent review organization may terminate the review and make a decision to reverse the Adverse Determination or the Final Adverse Determination.

Not later than one (1) business day after terminating the review and making the decision to reverse the Adverse Determination or the Final Adverse Determination, the independent review organization shall notify the commissioner, the Company, the Covered Person and, if applicable, the Covered Person's authorized representative in writing of such decision.

The assigned independent review organization shall review all the information and documents received. In reaching a decision, the independent review organization shall not be bound by any decisions or conclusions reached during the Company's Utilization Review process. Not later than one (1) business day after receiving any information submitted by the Covered Person or the Authorized Representative, the independent review organization shall forward such information to the Company. Upon the receipt of any information forwarded, the Company may reconsider its Adverse Determination or the Final Adverse Determination that is the subject of the review. Such reconsideration shall not delay or terminate the review.

The independent review organization shall terminate the review if the Company decides, upon completion of its reconsideration and notice to such organization to reverse its Adverse Determination or its Final Adverse Determination and provide coverage or payment for the health care service or treatment that is the subject of the Adverse Determination or the Final Adverse Determination.

Not later than one (1) business day after making the decision to reverse its Adverse Determination or its Final Adverse Determination, We shall notify the commissioner, the assigned independent review organization, the Covered Person and, if applicable, the Authorized Representative in writing of such decision.

In addition to the documents and information received, the independent review organization shall consider, to the extent the documents or information are available and the independent review organization considers them appropriate, the following in reaching a decision:

1. The Covered Person's medical records;
2. The attending health care professional's recommendation;
3. Consulting reports from appropriate health care professionals and other documents submitted by the Company, the Covered Person, the Authorized Representative or the Covered Person's treating Physician;
4. The terms of coverage under the Covered Person's plan to ensure that the independent review organization's decision is not contrary to the terms of coverage under such plan;
5. The most appropriate practice guidelines, which shall include applicable evidence-based standards and may include any other practice guidelines developed by the federal government, national or professional medical societies, medical boards or medical associations;
6. Any applicable clinical review criteria developed and used by the Company or its designee utilization review company; and
7. The opinion or opinions of the independent review organization's clinical peer or peers who conducted the review.

The independent review organization shall notify the commissioner, the Company, the Covered Person and, if applicable, the Authorized Representative in writing of its decision to uphold, reverse or revise the Adverse Determination or the final adverse determination, not later than:

1. For external reviews, forty-five (45) calendar days after such organization receives the assignment from the commissioner to conduct such review;
2. For external reviews involving a determination that the recommended or requested health care service or treatment is Experimental/Investigational, twenty (20) calendar days after such organization receives the assignment from the commissioner to conduct such review;
3. For EERs, as expeditiously as the Covered Person's medical condition requires, but not later than forty-eight (48) hours after such organization receives the assignment from the commissioner to conduct such review or seventy-two hours (72) after such organization receives such assignment if any portion of such forty-eight (48)-hour period falls on a weekend;
4. For EERs involving a health care service or course of treatment specified for substance abuse disorders (including co-occurring mental disorders) or mental disorders, as expeditiously as the Covered Person's medical condition requires, but not later than twenty-four (24) hours after such organization receives the assignment from the commissioner to conduct such review; and
5. For EERs involving a determination that the recommended or requested health care

service or treatment is Experimental/Investigational, as expeditiously as the Covered Person's medical condition requires, but not later than five (5) calendar days after such organization receives the assignment from the commissioner to conduct such review.

Such notice shall include:

- (1) A general description of the reason for the request for the review;
- (2) The date the independent review organization received the assignment from the commissioner to conduct the review;
- (3) The date the review was conducted;
- (4) The date the organization made its decision;
- (5) The principal reason or reasons for its decision, including what applicable evidence-based standards, if any, were used as a basis for its decision;
- (6) The rationale for the organization's decision;
- (7) Reference to the evidence or documentation, including any evidence-based standards, considered by the organization in reaching its decision; and
- (8) For a review involving a determination that the recommended or requested health care service or treatment is Experimental/Investigational:
 - (i) A description of the Covered Person's medical condition;
 - (ii) A description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that
 - (I) the recommended or requested health care service or treatment is likely to be more beneficial to the Covered Person than any available standard health care services or treatments, and
 - (II) the adverse risks of the recommended or requested health care service or treatment would not be substantially increased over those of available standard health care services or treatments;
 - (iii) A description and analysis of any medical or scientific evidence considered in reaching the opinion;
 - (iv) A description and analysis of any evidence-based standard; and
 - (v) Information on whether the clinical peer's rationale for the opinion is based on the documents and information.

Upon the receipt of a notice of the independent review organization's decision to reverse or revise an Adverse Determination or a final adverse determination, the Company shall immediately approve the coverage that was the subject of the Adverse Determination or the Final Adverse Determination.

CONTACT INFORMATION:

If any questions or concerns, contact:

TSS Administrative Services

PO Box 23615

Hilton Head Island, SC 29925

1-800-730-2417

Website: www.totalscholasticsolutions.com

You may also contact the Company at:

United States Fire Insurance Company

5 Christopher Way

Eatontown, NJ 07310

800-227-3745

Contact the Connecticut Insurance Department for assistance regarding any complaint, grievance or appeal at the following address:

Connecticut Insurance Department Consumer Affairs Department

P.O. Box 816 Hartford, CT 06142-0816

860-297-3900 or 800-203-3447

cid.ca@ct.gov

Contact the Office of Healthcare Advocate at:

State of Connecticut

Office of the Healthcare Advocate

P.O. Box 1543 Hartford, CT 06144

866-297-3992

Healthcare.advocate@ct.gov