PART V
SCHEDULE OF BENEFITS
MEDICAL EXPENSE BENEFITS-INJURY
CALIFORNIA LUTHERAN UNIVERSITY - INTERCOLLEGIATE SPORTS PLAN
2013-200828-8
INJURY ONLY BENEFITS

Maximum Benefit	**$75,000 (For Each Injury)**
Deductible	**$500 (For Each Injury)**
Coinsurance	**100% except as noted below**

Covered Medical Expenses will be paid under the Schedule of Benefits for loss Due to Injury to an Insured Person provided that treatment by a Physician: a) begins within 90 days after the date of Injury; and b) is received within 24 months after date of Injury.

The Benefits payable are as defined in and subject to all provisions of this policy and any endorsements thereto. Benefits will be paid up to the Maximum Benefit for each service as scheduled below.

Inpatient

Room & Board:	Usual and Customary Charges
Intensive Care:	Usual and Customary Charges
Hospital Miscellaneous:	Usual and Customary Charges
Physiotherapy:	Usual and Customary Charges $100 maximum per visit
($1,000 for each Injury maximum is combination of both inpatient and outpatient.)	
Assistant Surgeon:	Usual and Customary Charges
Anesthetist:	25% of Surgery Allowance
Registered Nurse:	Usual and Customary Charges
Physician's Visits:	Usual and Customary Charges
Pre-admission Testing:	Usual and Customary Charges

Outpatient

Day Surgery Miscellaneous:	Usual and Customary Charges
(Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Charge Index.)	
Assistant Surgeon:	Usual and Customary Charges
Anesthetist:	25% of Surgery Allowance
Physician's Visits:	Usual and Customary Charges
Physiotherapy:	Usual and Customary Charges $100 maximum per visit
($1,000 for each Injury maximum is combination of both inpatient and outpatient.)	
Medical Emergency:	Usual and Customary Charges
Positive X-rays:	Usual and Customary Charges
Negative X-rays:	Usual and Customary Charges
Laboratory:	Usual and Customary Charges
Tests & Procedures:	Usual and Customary Charges
Injections:	Usual and Customary Charges
Prescription Drugs:	Usual and Customary Charges

Other

Ambulance:	Usual and Customary Charges $5,000 maximum
Durable Medical Equipment:	Usual and Customary Charges
Consultant:	Usual and Customary Charges
Dental:	Usual and Customary Charges $500 maximum per tooth
(Benefits paid on Injury to Sound, Natural Teeth only.)	
Repatriation:	No Benefits
Medical Evacuation:	No Benefits
***AD&D:**	$1,250 - $5,000 maximum

MAJOR MEDICAL

Maximum Benefit **No Benefits**

CATASTROPHIC MEDICAL

Maximum Benefit **No Benefits**

SHC Referral Required: Yes ( ) No (X) **Conversion Permitted:** Yes ( ) No (X)

(X) 104 Week Benefit Period or **( ) Extension of Benefits**

Pre Admission Notification: Yes ( ) No (X)

Other Insurance: **(X) *Excess Insurance** **( ) Excess Motor Vehicle** **( ) Primary Insurance**

*If benefit is designated, see endorsement attached.

PART VII
EXCLUSIONS AND LIMITATIONS

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

1. Acupuncture;

2. Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this policy;

3. Dental treatment, except for accidental Injury to Natural Teeth;

4. Elective Surgery or Elective Treatment;

5. Eye examinations, eye refractions, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses;

6. Hearing examinations or hearing aids;

7. Loss sustained or contracted in consequence of the Insured's being intoxicated or under the influence of any controlled substance unless administered on the advice of a Physician;

8. Injury for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation;

9. Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

10. Prescription Drug Services - no benefits will be payable for:
    a) Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use;
    b) Immunization agents, biological sera, blood or blood products administered on an outpatient basis;
    c) Drugs labeled, "Caution - limited by federal law to investigational use" or experimental drugs;
    d) Growth hormones; or
    e) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription.

12. Services provided normally without charge by the Health Service of the Policyholder; or services covered or provided by the student health fee;

13. Sickness or disease in any form;

14. Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planing, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;

15. Suicide or attempted suicide while sane or insane (including drug overdose); or intentionally self-inflicted Injury;

16. Supplies, except as specifically provided in the policy; and

17. Treatment in a Government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

EXCESS PROVISION
Injury Only

No benefit of this policy is payable for any expense incurred for Injury which is paid or payable by other valid and collectible insurance, except for Automobile Medical Payments Insurance.

This Excess Provision will not be applied to the first $100 of Covered Medical Expenses incurred.

Covered Medical Expenses excludes amounts not covered by the primary carrier due to penalties imposed on the Insured for failing to comply with policy provisions or requirements.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

Loss of Life, Limb or Sight

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

Payment under this endorsement when added to the payment under the "Basic Medical Expense Benefit" (and under Major Medical, if coverage is afforded under Major Medical) shall not exceed the policy Maximum Benefit.

For Loss Of:

Life	$5,000
Both Hands, Both Feet, or Sight of Both Eyes	$5,000
One Hand and One Foot	$5,000
Either One Hand or One Foot and Sight of One Eye	$5,000
One Hand or One Foot or Sight of One Eye	$2,500
Entire Thumb and Index Finger of Either Hand	$1,250

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

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

PRE-ADMISSION NOTIFICATION

UMR Care Management should be notified of all Hospital Confinements prior to admission.

1. **PRE-NOTIFICATION OF MEDICAL NON-EMERGENCY HOSPITALIZATIONS:** The patient, Physician or Hospital should telephone 1-877-295-0720 at least five working days prior to the planned admission.

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

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

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

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

POLICY ENDORSEMENT

In consideration of the premium charged, it is hereby understood and agreed that the policy to which this endorsement is attached is amended as follows:

INDEPENDENT MEDICAL REVIEW

Every disability insurance contract that is issued, amended, renewed, or delivered in this state on or after January 1, 2000, shall, effective January 1, 2001, provide an insured with the opportunity to seek an independent medical review whenever health care services have been denied, modified, or delayed by the insurer, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary, or are not a covered benefit under the contract that applies to the insured. An Insured Person may designate an agent to act on his or her behalf. The provider may join with or otherwise assist the insured in seeking an independent medical review, and may advocate on behalf of the insured.

An insured may apply to the department for an independent medical review when all of the following conditions are met:

1. A.) The insured's provider has recommended a health care service as medically necessary, or

   B.) The insured has received urgent care or emergency services that a provider determined was medically necessary, or

   C.) The insured, in the absence of a provider recommendation under subparagraph (A) or the receipt of urgent care or emergency services by a provider under subparagraph (B), has been seen by a provider for the diagnosis or treatment of the medical condition for which the insured seeks independent review.

2. The disputed health care service has been denied, modified, or delayed by the insurer, based in whole or in part on a decision that the health care service is not medically necessary or are not a covered benefit under the contract that applies to the insured.

3. The insured has filed a grievance with the insurer, and the disputed decision is upheld or the grievance remains unresolved after 30 days. The insured shall not be required to participate in the insurer's grievance process for more than 30 days. In the case of a grievance that requires expedited review, the insured shall not be required to participate in the insurer's grievance process for more than three days.

The Independent Medical Review Process

An insured may apply to the department for an independent medical review of a decision to deny, modify, or delay health care services, based in whole or in part on a finding that the disputed health care services are not medically necessary, or are not a covered benefit under the contract that applies to the insured within six months of such decision. However, the commissioner may extend the application deadline beyond six months if the circumstances of a case warrant the extension.

As part of its notification to the insured regarding a disposition of the insured's grievance that denies, modifies, or delays health care services, the insurer shall provide the insured with a one-page application form approved by the department, and an addressed envelope, which the insured may return to initiate an independent medical review. The insurer shall include on the form any information required by the department to facilitate the completion of the independent medical review, such as the insured's diagnosis or condition, the nature of the disputed health care service sought by the insured, a means to identify the insured's case, and any other material information. The form shall also include the following:

1. Notice that a decision not to participate in the independent review process may cause the insured to forfeit any statutory right to pursue legal action against the insurer regarding the disputed health care service.

2. A statement indicating the insured's consent to obtain any necessary medical records form the insurer, or any provider the insured may have consulted on the matter, to be signed by the insured.

3. Notice of the insured's right to provide information or documentation, either directly or through the insured's provider, regarding any of the following:

A.) A provider recommendation indicating that the disputed health care service is medically necessary for the insured's medical condition.

B.) Medical information or justification that a disputed health care service, on an urgent care or emergency basis, was medically necessary for the insured's medical condition.

C.) Reasonable information supporting the insured's position that the disputed health care service is or was medically necessary for the insured's medical condition, including all information provided to the insured by the insurer or any providers, still in the possession of the insured, concerning an insurer or provider decision regarding disputed health care services, and a copy of any materials the insured submitted to the insurer, still in the possession of the insured, in support of the grievance, as well as any additional material that the insured believes is relevant.

Upon notice from the department that the insured has applied for an independent medical review, the insurer shall provide to the independent medical review organization designated by the department a copy of all of the following documents within three business days of the insurer's receipt of the department's notice of a request by an insured for an independent review:

1. A.) A copy of all of the insured's medical records in the possession of the insurer relevant to each of the following:
   (i) The insured's medical condition.
   (ii) The health care services being provided by the insurer and its contracting providers for the condition.
   (iii) The disputed health care services requested by the insured for the condition.

B.) Any newly developed or discovered relevant medical records in the possession of the insurer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The insurer shall concurrently provide a copy of medical records required by this subparagraph to the insured or the insured's provider, if authorized by the insured, unless the offer of medical records is declined or otherwise prohibited by law. The confidentiality of all medical record information shall be maintained pursuant to applicable state and federal laws.

2. A copy of all information provided to the insured by the insurer concerning insurer and provider decisions regarding the insured's condition and care, and a copy of any materials the insured or the insured's provider submitted to the insurer in support of the insured's request for disputed health care services. This documentation shall include the written response to the insured's grievance. The confidentiality of any insured medical information shall be maintained pursuant to applicable state and federal laws.

3. A copy of any other relevant documents or information used by the insurer in determining whether disputed health care services should have been provided, and any statements by the insurer explaining the reasons for the decision to deny, modify, or delay disputed health care services on the basis of medical necessity or not being a covered benefit under the contract that applies to the insured. The insurer shall concurrently provide a copy of documents required by this paragraph, except for any information found by the commissioner to be legally privileged information, to the insured and the insured's provider. The department and the independent review organization shall maintain the confidentiality of any information found by the commissioner to be proprietary information of the insurer.

This endorsement takes effect and expires concurrently with the policy to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.