This student health insurance coverage is compliant with the HHS ruling of March 16, 2012 that pertains to student health insurance; however, it may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits pertaining to other types of health insurance other than Student Health Insurance. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Your student health insurance coverage has an annual limit of $500,000 per policy year on all covered benefits. If you have any questions or concerns about this notice, contact the Underwriting Company stated in this brochure. You may be eligible for coverage under a group health plan of a parent's employer or under a parent's individual health insurance policy if you are under the age of 26. Contact the plan administrator of the parent's plan for more information.
ELIGIBILITY AND ENROLLMENT

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE:
As of January 1, 2009, the Massachusetts Health Care Reform Law requires that Massachusetts residents, eighteen (18) years of age and older, must have health coverage that meets the Minimum creditable Coverage standards set by the Commonwealth Health Insurance Connector, unless waived from the health insurance requirement based on affordability or individual hardship. For more information call the Connector at 1-877-MA-ENROLL or visit the Connector website (www.mahealthconnector.org).

This health plan satisfies Minimum Creditable Coverage standards that are effective during the term of coverage as part of the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirements that you have health insurance meeting these standards.

If you have questions about this notice, you may contact the Division of Insurance by calling (617) 521-7794 or visiting its website at www.mass.gov/doi.

Massachusetts Law mandates that all full-time and three quarter (3/4) time students have health insurance coverage. The law requires that your insurance be equivalent to or better than the Massachusetts Health Care Reform Law. If you purchase this plan, you will satisfy the statutory requirements that you have health insurance meeting these standards.

Voluntary Participation means that only those eligible persons who have executed Our enrollment form; and the fee will remain on their student account bill.

Part time students with less than three (3) credits per semester are eligible to enroll on a voluntary basis if the student participates in a degree-granting program. Voluntary Participation means that only those eligible persons who have executed Our enrollment form; and paid the required premium are insured under this Policy. Contact Bay Path College for enrollment information.

POLICY TERM AND PLAN COSTS

Effective Dates: Insurance under this Policy will become effective on the later of: 1) the Policy effective date; 2) the beginning date of the term for which premium has been paid; 3) the day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School; or 4) the day after the date of postmark if the Enrollment Form is mailed.
No other refunds will be allowed.

DEFINITIONS

Accident means a sudden, unexpected and unforeseen, external event that causes injury to an Insured Person. The Accident must occur while coverage is in effect for the Insured Person.

Co-payment means the amount of Usual and Reasonable expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Co-payment amounts are shown in the Schedule of Benefits.

Covered Injury means a bodily injury that is:
1. Sustained by an Insured Person while he/she is insured under the Policy or the School’s prior policies; and
2. Caused by and accident directly and independently of all other causes.

Coverage under the School’s policies must have remained continuously in force:
1. From the date of Injury; and
2. Until the date services or supplies are received, for them to be considered as a Covered Medical Expense under the Policy.

Covered Medical Expense means those charges for any treatment, service or supplies that are:
1. Not in excess of the Usual and Reasonable charges therefore:
2. Not in excess of the charges that would have been made in the absence of this insurance; and
3. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Medical Expense includes those charges for treatment, services or supplies delivered in accordance with the healing practices of Christian Science.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which:
1. Causes a loss while the Policy is in force; and
2. Which results in Covered Medical Expenses.

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

Dependent means:
1. An Insured Student’s lawful spouse;
2. An Insured Student’s dependent biological or adopted child or stepchild under age twenty-six (26); and
3. An Insured Student’s unmarried biological or adopted child or stepchild who has reached age twenty-six (26) and who is:
a. primarily dependent upon the Insured Student for support and maintenance; and

Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when a Insured Student enrolls a new disabled child under the plan.

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

Elective Treatment includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. Elective Surgery includes, but is not limited to, circumcision, vasectomy, breast reduction, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

Emergency Medical Condition means a medical condition, which:
1. Manifests itself by acute symptoms of sufficient severity (including severe pain); and
2. Causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention might result in:
   a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part.

Hospital means an institution that:
1. Operates as a Hospital pursuant to law;
2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. Provides 24-hour nursing service by Registered Nurses on duty or call;
4. Has a staff of one or more Physicians available at all times; and

PREMIUM REFUND POLICY

Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:
1. For any student who does not attend school during the first thirty-one (31) days of the period for which coverage is purchased. Such a student will not be covered under the Policy and a full refund of the premium will be made.
2. For Insured Persons entering the Armed Forces of any country. Such persons will not be covered under the Policy as of the date of his/her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

Traditional Undergraduate Students

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One-Day Saturday Students

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Physician Assistant Students

Forensic and Occupational Therapy Graduate Students

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You, Your, Yours means the insured student.

**BENEFITS**

A $100 Policy year Deductible for Covered Medical Expenses must be paid by each Insured Person before benefits are payable under the Policy. The Policy will pay 80%, except as specifically stated, of Covered Medical Expenses incurred by a Covered Person due to a Covered Sickness or Covered Injury, up to an aggregate maximum benefit of $500,000 per Policy Year (for both Domestic and International Students). Covered Medical Expenses are considered incurred on the date the treatment or service is rendered or the supply is furnished.

Covered Medical Expenses are shown in the Schedule of Benefits. Other mandated benefits are shown below.

**MANDATED BENEFITS**

State mandated benefits will be subject to all deductibles, Co-payments, co-insurance, limitations, or other provisions of the policy, unless specifically stated otherwise. If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

**Autism Spectrum Disorder Benefit:** We will provide coverage for the diagnosis and treatment of Autism Spectrum Disorder on the same basis as any other Covered Sickness. Treatment of Autism Spectrum Disorders includes the following care prescribed, provided or ordered for an Insured Person diagnosed with one of the Autism Spectrum Disorders by a licensed physician or a licensed psychologist: Habilitative or Rehabilitative Care; Pharmacy Care, Psychiatric Care; Psychological Care and Therapeutic Care. For the purpose of this benefit: Autism Spectrum Disorders means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

**Cancer Treatment Benefits:** We will pay the expenses incurred for treatment of any form of cancer or leukemia up to $350 per policy year. Such coverage will be subject to a written prescription from a licensed physician.

**Clinical Trials for Cancer:** We will pay the expenses incurred for a bone marrow transplant or transplants for Insured Persons who have been diagnosed for breast cancer that has progressed to metastatic disease, provided that the Insured Person meets the criteria established by the Massachusetts Department of Public Health. This criteria will be consistent with medical research protocols reviewed and approved by the National Cancer Institute.

**Leukocyte Testing:** We will pay the expenses incurred for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. This will include the costs of testing for A, B, or DR antigens or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.

**Scalp Hair Prostheses:** We will pay the expenses incurred for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia up to $350 per policy year. Coverage for the services required under this benefit are provided subject to the terms and conditions generally applicable to any other prosthesis that would be covered by the Policy.

**Orally Administered Cancer Medications:** We will pay the expenses incurred for the care of an Insured Person diagnosed for breast cancer that has progressed to metastatic disease, provided that the Insured Person has been provided with a bone marrow transplant donor suitability. This will include the costs of testing for A, B, or DR antigens or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.

**Oral and Parenteral Medications:** We will pay the expenses incurred for oral or parenteral medications for a Covered Person who is diagnosed for breast cancer that has progressed to metastatic disease, provided that the Insured Person has been provided with a bone marrow transplant donor suitability. This will include the costs of testing for A, B, or DR antigens or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.

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administered or injected cancer medications that are covered as medical benefits

For purposes of this benefit:

Patient Care Service means a health care item or service that is furnished to an Insured Person enrolled in a Qualified Clinical Trial, which is consistent with the standard of care for someone with the Insured Person's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the Insured Person did not participate in the clinical trial. Patient Care Services does NOT include:

1. An investigational drug or device but a drug or device that has been approved for use in the Qualified Clinical Trial, whether or not the Food and Drug Administration has approved the drug or device for use in treating the Insured Person's particular condition will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device.

2. Non-health care services that an Insured Person may be required to receive as a result of being enrolled in the clinical trial.

3. Costs associated with managing the research associated with the clinical trial.

4. Costs that would not be covered for non-investigational treatments.

5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the clinical trial.

6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care.

7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but which are being provided at a greater frequency, intensity or duration.

8. Services or costs that are not otherwise covered under the Policy.

Qualified Clinical Trial means a trial that meets the following conditions:

1. The clinical trial is intended to treat cancer in an Insured Person who has been so diagnosed.

2. The clinical trial has been peer reviewed and is approved by one of the United States National Institutes of Health, a qualified non-governmental research entity identified in guidelines issued by the National Institute of Health for center support grants, the United States Food and Drug Administration pursuant to an investigational new drug exemption, the United States Department of Defense or Veterans Affairs, or with respect to Phase 11, III or IV clinical trials only, a qualified institutional review board.

3. The facility and personnel conducting the trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise.

4. With respect to Phase I clinical trials, the facility will be an academic medical center or an affiliated facility and the clinicians conducting the trial will have staff privileges at said academic medical center.

5. The Insured Person meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.

6. The Insured Person has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.

7. The available clinical or pre-clinical data provide a reasonable expectation that the Insured Person's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.

8. The clinical trial does not unjustifiably duplicate existing studies.

9. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Insured Person.

Cardiac Rehabilitation: We will pay the Usual and Reasonable expenses incurred for cardiac rehabilitation. Cardiac rehabilitation shall mean multidisciplinary treatment of an Insured Person with documented cardiovascular disease, which shall be provided in either a Hospital or other setting and which shall meet standards promulgated by the Commissioner of public health Benefits will include, but is not limited to, outpatient treatment which is to be initiated within twenty-six (26) weeks after the diagnosis of such disease.

Cleft Palate and Cleft Lip Benefit: We will pay the Usual and Reasonable expenses incurred for an Insured Person under the age of eighteen (18) for the cost of treating congenital conditions of cleft lip and cleft palate if such services are prescribed by the treating Physician or surgeon. Benefits are payable on the same basis as any other Covered Sickness. The coverage shall include benefits for:

1. Medical, dental, oral and facial surgery;

2. Surgical management and follow-up care by oral and plastic surgeons;

3. Orthodontic treatment and management;

4. Preventative and restorative dentistry to ensure good health;

5. Adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology and nutrition services.

This benefit does not include payment for dental or orthodontic treatment not related to the management of the congenital conditions of cleft lip and cleft palate.

Diabetes Equipment, Supplies and Service Benefit: We will pay the Usual and Reasonable expenses incurred for the following equipment, supplies and services in the treatment of diabetes on the same basis as for any other Covered Sickness. Such equipment, supplies or service must be prescribed by a health care professional legally authorized to prescribe such items for the diagnosis or treatment of insulin-dependent, insulin-using, gestational and non-insulin-dependent diabetes.

1. Equipment and supplies for the treatment of diabetes include, but are not limited to the following. We will pay the Usual and Reasonable charges incurred for such supplies.

   a. Lancets and automatic lancering devices
   b. Glucose test strips
   c. Blood glucose monitors
   d. Blood glucose monitors for visually impaired
   e. Control solutions used in blood glucose monitors;
   f. Diabetes data management systems for management of blood glucose
   g. Urine testing products for glucose and ketones
   h. Oral anti-diabetic agents used to reduce blood sugar levels
   i. Alcohol swabs
   j. Syringes
   k. Injection aids including insulin drawing up devices for the visually impaired
   l. Cartridges for the visually impaired
   m. Disposable insulin cartridges and pen cartridges
   n. Insulin pumps and equipment for the use of the pump including batteries
   o. Insulin infusion devices
   p. Oral agents for treating hypoglycemia such as glucose tablets and gels
   q. Glucagon for injection to increase blood glucose concentration
   r. Visual magnifying aids for use by the legally blind
   s. Voice synthesizers for blood glucose monitors for use by the legally blind
   t. Other diabetes equipment and related supplies to the treatment of diabetes

2. We will pay the Usual and Reasonable charges for the following:

   a. Insulin and prescribed oral diabetes medications that influence blood sugar levels, on the same basis as other Prescription Drugs;
   b. Laboratory tests, including glycosylated hemoglobin, or HDLc, tests; an
   c. Therapeutic molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating Physician and prescribed by a podiatrist or other
Any pre-existing condition limitations of the Policy will not apply to:

6. For the purposes of this section, confinement will mean that the Insured Person must be confined in an either:
   a. A general hospital licensed to provide such services;
   b. A facility under the direction and supervision of the Department of Mental Health;
   c. A private mental hospital licensed by the Department of Mental Health;
   d. A substance abuse facility licensed by the Department of Public Health.

Outpatient care and treatment means care or treatment that is:
   1. Provided by a licensed hospital;
   2. By a mental health or substance abuse clinic licensed by the Department of Public Health;
   3. By an approved (by the Department of Mental Health) community mental health center or other mental health clinic or day care center which furnishes mental health services; or
   4. Consultation or diagnostic or treatment sessions, provided in a professional office or home based services provided, however, that such services are rendered by a licensed mental health professional including a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health practitioner, or a substance abuse counselor.

For purposes of this section, confinement will mean that the Insured Person must be confined in an either:
   a. A general hospital licensed to provide such services;
   b. A facility under the direction and supervision of the Department of Mental Health;
   c. A private mental hospital licensed by the Department of Mental Health;
   d. A substance abuse facility licensed by the Department of Public Health.

Outpatient care and treatment means care or treatment that is provided:
   1. By a licensed hospital;
   2. By a mental health or substance abuse clinic licensed by the Department of Public Health;
   3. By an approved (by the Department of Mental Health) community mental health center or other mental health clinic or day care center which furnishes mental health services; or
   4. Consultation or diagnostic or treatment sessions, provided in a professional office or home based services provided, however, that such services are rendered by a licensed mental health professional including a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health practitioner, or a substance abuse counselor.

Infertility Benefit: We will pay the usual and reasonable expenses incurred for the diagnosis and treatment of infertility to the same extent that benefits are provided for other pregnancy-related procedures. We will pay the expenses incurred for:
   1. Artificial insemination (AI);
   2. In vitro fertilization and embryo placement (IVF-EP);
   3. Gamete intrafallopian transfer (GIFT);
   4. Sperm, egg, and/or inseminated egg procurement and processing and banking of sperm; or
   5. Inseminated eggs, to the extent such costs are not covered by the donor’s insurer, if any;
   6. Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility; or
   7. Zygote intrafallopian transfer (ZIFT).

Zygote intrafallopian transfer (ZIFT).

Any pre-existing condition limitations of the Policy will not apply to the benefit.

For the purposes of this benefit, Infertility means the condition of an Insured Person who is unable to conceive or produce conception during a period of one (1) year if the female is age 35 or younger or during a period of six (6) months if the female is over the age of 35. For the purposes of meeting the criteria for infertility for this benefit, if a person conceives but is unable to carry that pregnancy to live birth, the period of time she attempted to conceive prior to achieving that pregnancy shall be included in the calculation of the one (1) year or six (6) month period, as applicable.

When prescription drugs are prescribed as part of the infertility treatment, we will pay the usual and reasonable expenses incurred on the same basis as for any other prescription drugs. We will not cover the following as part of an infertility treatment program:

1. Any experimental infertility procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner;
2. Surrogacy;
3. Reversal of voluntary sterilization; and
4. Cryopreservation of eggs.

Mastectomy Surgery and Rehabilitation Benefit: The surgical procedure known as a mastectomy will be covered under the Surgery Benefit of this Policy. Under this benefit, we will pay the expenses incurred for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Insured Person following a covered mastectomy. As used in this benefit, prosthetic device includes the initial prosthetic device and any subsequent prosthetic devices provided pursuant to an order of the Insured Person’s Physician and surgeon.

Mental Illness Benefit: We will pay the usual and reasonable expenses incurred for the diagnosis and treatment of the following Biologically-Based Mental Disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM:

1. Schizophrenia;
2. Schizoaffective disorder;
3. Major depressive disorder;
4. Bipolar disorder;
5. Paranoia and other psychotic disorders;
6. Obsessive-compulsive disorder;
7. Panic disorder;
8. Delirium and dementia;
9. Affective disorders;
10. Eating disorders;
11. Post-traumatic stress disorder; and
12. Substance abuse disorders.

We will also pay the usual and reasonable expenses for the diagnosis and treatment of rape-related mental or emotional disorders to victims of a rape or victims of an assault with intent to commit rape whenever the costs of such diagnosis and treatment exceed the maximum compensation awarded to such victims pursuant Massachusetts law.

We will also pay the usual and reasonable expenses for covered children and adolescents under the age of 19 for the diagnosis and treatment of non-Biologically-Based Mental Disorders or other behavioral or emotional disorders which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent. Such interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to:

1. An inability to attend school as a result of such a disorder;
2. The need to hospitalize the child or adolescent as a result of such a disorder; or
3. A pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

We shall continue to provide such benefits to any adolescent who is engaged in an ongoing course of treatment beyond the adolescent’s ninetenth birthday until said course of treatment, as specified in said adolescent’s treatment plan, is completed and while coverage under the Policy remains in effect.

We will also pay benefits for the diagnosis and treatment of all other mental disorders not otherwise defined as Biologically-Based Mental Disorders during each twelve (12) month period for a minimum of sixty (60) days of inpatient treatment and for a minimum of twenty-four (24) outpatient visits. We will cover inpatient, intermediate, and outpatient services that shall permit active and non-custodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting.

For purposes of this section, confinement will mean that the Insured Person must be confined in an either:

1. A general hospital licensed to provide such services;
2. A facility under the direction and supervision of the Department of Mental Health;
3. A private mental hospital licensed by the Department of Mental Health; or
4. A substance abuse facility licensed by the Department of Public Health.

Outpatient care and treatment means care or treatment that is provided:

1. By a licensed hospital;
2. By a mental health or substance abuse clinic licensed by the Department of Public Health;
3. By an approved (by the Department of Mental Health) community mental health center or other mental health clinic or day care center which furnishes mental health services; or
4. Consultation or diagnostic or treatment sessions, provided in a professional office or home based services provided, however, that such services are rendered by a licensed mental health professional including a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health practitioner, or a substance abuse counselor.
5. health clinical specialist or a licensed marriage and family therapist within the lawful scope of practice for such therapist. For the purposes of this Benefit, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be on the same basis as any other Covered Sickness.

**Non-Prescription Enteral Formulas and Low Protein Food Formulas Benefit:** We will pay the Usual and Reasonable expenses up to a maximum of $5,000 per Policy Year, incurred for non-prescription enteral formulas which when recommended by the Insured Person's Physician for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastrointestinal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids. We will pay up to the benefit amount shown in the Schedule of Benefits.

**Prosthetic Devices Benefit:** We will pay the Usual and Reasonable expense incurred for Prosthetic Devices and repairs under the same terms and conditions that apply to other durable medical equipment covered under the policy. For the purpose of this benefit, Prosthetic Device means an artificial limb device to replace, in whole or in part, an arm or leg.

**Telemedicine Consultation Benefit:** We will pay the Usual and Reasonable expenses incurred for Telemedicine as if such consultation was provided through in-person consultation. For the purpose of this benefit, Telemedicine shall mean the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment. Telemedicine shall not include the use of audio-only telephone, facsimile machine or email.

**Treatment of Speech, Hearing (including Hearing Aid Purchase), and Language Disorders Benefit:** We will pay the Usual and Reasonable expenses incurred in the diagnosis and treatment of speech, hearing and language disorders. Such diagnosis and treatment must be provided by individuals licensed as speech-language pathologists or audiologists or hearing instrument specialists operating within the scope of their licenses. Services may be provided in a Hospital, clinic or private office. Coverage is not provided for the diagnosis or treatment of speech, hearing or language in a school-based setting.

We will also provide coverage for the expenses incurred in the purchase of a hearing aid for an Insured Person twenty-one (21) years of age or younger when prescribed or recommended by a licensed Physician. We pay the full cost of one (1) hearing aid per hearing impaired ear, up to two thousand dollars ($2,000) for each hearing aid every thirty-six (36) months. Benefits include fitting, adjustments and supplies, including ear molds. An Insured 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.

**MEDICAL EVACUATION AND REPATRIATION BENEFIT**

To be eligible for this benefit, a Student must: a) be an International Student enrolled in the authorized college or school during the period for which coverage is purchased, or b) be an Eligible Domestic Student participating in a study abroad program sponsored by the College or School.

An eligible International Student must meet the definition of same. An International Student may also enroll his or her Dependent under this Section by payment of additional premium.

As used in this Section, an Eligible Domestic Student means a permanent resident of the United States who is enrolled at the college or school and who is temporarily participating in international educational activities outside their Home Country. The maximum combined benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits.

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

- The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five (5) or more consecutive days immediately prior to medical evacuation;
- Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;
- We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;
- No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person’s insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or thirty-one (31) days after the date of termination;
- Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and
- Transportation must be by the most direct and economical route.

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

**EXCLUSIONS & LIMITATIONS**

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of that Act. The plan does not provide benefits for:

1. Treatment to the teeth, including surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. This exclusion does not apply to the repair of injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
2. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
3. Services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental injury.
4. Routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
5. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Policy.
6. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within twenty-four (24) hours of the Accident or results from Reconstructive Surgery. For the purposes of this provision, Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible. For the purposes of this provision, Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.
7. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
8. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
9. An Insured person's: Committing or attempting to commit a felony, being engaged in an illegal occupation, or participation in a riot.
10. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
11. Expenses covered under any Workers Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
12. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercolllegiate sports.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. Services or supplies not related to the medical care of the Insured Person's Injury or Sickness.
15. Expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the Policy.
16. Expenses payable under any prior Policy which was in force for the person making the claim.
17. Expense incurred after the date insurance terminates as to the Insured Person and the end of the Benefit Period specified in the Benefit Schedule.
18. Elective abortion.
19. Sky diving, ultra light aircraft, parasailing, sail planing, hang gliding, bungee jumping, or other hazardous sport or hobby.
20. Braces and appliances, except as specifically provided in the Schedule of Benefits.
21. Expenses that are not recommended and approved by a Physician.

PRE-EXISTING CONDITIONS LIMITATION
(Not applicable to any Covered Person under the age of 19.)
The Policy does not cover Pre-existing Conditions for the first six (6) months following the enrollment date of an Insured Person for coverage under the Policy. However, We will waive this Limitation for an Insured Person who:
1. Has been Continuously Insured for at least twelve (12) consecutive months under one or more student insurance policies issued to the Policyholder; or
2. Can provide satisfactory evidence of prior Creditable Coverage. To qualify for this waiver, an Insured must fulfill all of the following requirements:
   a. He or she must not be covered under any other health insurance;
   b. He or she must have had health insurance for a total of 18 months, with no break in coverage longer than 63 days; and
   c. His or her most recent coverage must meet the definition of Creditable Coverage in the Policy.

COORDINATION OF BENEFITS
If an Insured Person is covered by more than one health care plan, he or she may not be able to collect benefits from both plans. An insured should read all of the rules very carefully, including the coordination of benefits section and compare them with the rules of any other plan that covers an insured or his/her family.

TERMINATIONS
Your coverage will terminate on the earlier to occur of these dates:
1. The date the Policy terminates for all insured persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date an Insured Person ceases to be eligible for the insurance; or
4. The date an Insured Person enters military service.
Premium refund will be made only in the event of the insured student entering the armed services.

Extension of Benefits: Coverage under this Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended as follows: If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to a minimum of thirty-one (31) days from the Termination Date while such confinement continues.

CLAIM PROCEDURES
In the event of a Covered Injury or Sickness, claims must be reported by the Insured Student directly to:

Cigna
1000 Great West Drive
Kennett, MO 63857-3749
Electronic Payor ID: 62308

CONFORMITY WITH STATE STATUTES
Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which is issued, is hereby amended to conform to the minimum requirements of such statutes.
QUESTIONS? NEED MORE INFORMATION?
Direct all questions regarding how to enroll, benefits available under the Plan, claim procedures, status of a submitted claim or payment of a claim to Consolidated Health Plans.

CLAIMS ADMINISTRATOR
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540 or Toll Free (800) 633-7867
www.chpstudent.com
Group Number: S210709

For information about the Restat Prescription Drug Program, please visit: www.restat.com

For a copy of the Company's privacy notice you may:
go to: www.consolidatedhealthplan.com/about/hipaa
or
Request one from the Health Office at your School
or
Request one from:
Commercial Travelers Mutual Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502
(Please indicate the school you attend with your written request)

This plan is underwritten by:
National Guardian Life Insurance Company
As Policy Form Number: NBH-280(2013)-MA.

National Guardian Life Insurance Company is not affiliated with Guardian Life Insurance Company of America aka The Guardian or Guardian Life.

Representations of this plan must be approved by the Company

This Certificate of Insurance is intended only for quick reference and does not limit or amplify the coverage as described in the master policy which contains complete terms and provisions. A copy of the master policy is on file at the college.

VISION DISCOUNT PROGRAM
A Vision Discount Program is available to students enrolled in the Bay Path College Student Health Insurance Plan. Students will be responsible for paying for services up front but will receive a discount off retail prices. For more information please go to: www.chpstudent.com

EMERGENCY MEDICAL TRAVEL ASSISTANCE
FrontierMEDEX ACCESS services is a comprehensive program providing you with 24/7 emergency medical and travel assistance services including emergency security or political evacuation, repatriation services and other travel assistance services when you are outside your home country or 100 or more miles away from your permanent residence. FrontierMEDEX is your key to travel security.

For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867.

If you have a medical, security, or travel problem, simply call FrontierMEDEX for assistance and provide your name, school name, the group number shown on your ID card, and a description of your situation. If you are in North America, call the Assistance Center toll-free at: 1-800-527-0218 or if you are in a foreign country, call collect at: 1-410-453-6330.

If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center. FrontierMEDEX will then take the appropriate action to assist you and monitor your care until the situation is resolved.

Your out-of-pocket costs may be lower when you utilize the Cigna PPO Network. For a listing of Cigna PPO Providers, go to www.cigna.com or contact Consolidated Health Plans at (413) 773-4540, toll-free at (800) 633-7867, or www.chpstudent.com for assistance.
## BAY PATH COLLEGE 2013-2014 SCHEDULE OF BENEFITS

### Deductible

| Benefit Period | $100 per Policy Year |

### Aggregate Medical Maximum

| Policy Year | $500,000 per Policy Year |

### Coinsurance

| 60% |

## INPATIENT BENEFITS

### Hospital Room and Board Expense

- **Benefit:** including general nursing care. **Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed.**
- **Per Coinsurance Stated Above**

### Intensive Care

- **Benefit:** including 24-hour nursing care.
- **Per Coinsurance Stated Above**

### Hospital Miscellaneous Expenses

- **Benefit:** while Hospital Confined or as a precondition for being Hospital Confined. **Services include:** but are not limited to cost for use of an operating room; prescribed medicines; laboratory tests; therapeutic services; x-ray examinations; casts and temporary surgical appliances; oxygen, oxygen tent; blood and blood plasma; and miscellaneous supplies.
- **Per Coinsurance Stated Above**

### Preadmission Testing

- **Benefit:** routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital.
- **Per Coinsurance Stated Above**

### Inpatient Surgery Including Surgeon, Anesthetist, and Assistance Surgeon Services

- **Benefit:** for inpatient surgery (including pre- and post-operative visits). If two (2) or more surgical procedures are performed through the same incision or in immediate succession at the same session, benefits equal the benefit payable for the procedure with the highest benefit value. **This benefit is not payable in addition to Physician's visits.**
- **Per Coinsurance Stated Above**

### Physical Therapy

- **Benefit:** when prescribed by the attending Physician.
- **Per Coinsurance Stated Above**

### Physician's Visits

- **Benefit:** not to exceed one (1) visit per day. **Surgeon's fees are not payable under this benefit.**
- **Per Coinsurance Stated Above**

## OUTPATIENT BENEFITS

### Outpatient Surgery Including Surgeon, Anesthetist, and Assistance Surgeon Services

- **Benefit:** for outpatient surgery (including fees for pre- and post-operative visits). If two (2) or more surgical procedures are performed through the same incision or in immediate succession at the same session, benefits equal the benefit payable for the procedure with the highest benefit value.
- **Per Coinsurance Stated Above**

### Outpatient Surgery Miscellaneous

- **Benefit:** (excluding non-scheduled surgery) for surgery performed in a hospital emergency room, trauma center, physician's office, outpatient surgical center or clinic. **Services include:** operating room; therapeutic services; oxygen, oxygen tent; blood and blood plasma; and miscellaneous supplies.
- **Per Coinsurance Stated Above**

### Outpatient Miscellaneous Expenses

- **Benefit:** including other reasonable expenses for services and supplies that have been prescribed by the attending Physician.
- **Per Coinsurance Stated Above**

### Physician's Visits

- **Benefit:** limited to one (1) visit per day. **Surgeon fees are not payable under this benefit.**
- **Per Coinsurance Stated Above**

### Emergency Services

- **Benefit:** in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, trauma center, physician's office, outpatient surgical center or clinic. Services include operating room; therapeutic services; oxygen, oxygen tent; blood and blood plasma; and miscellaneous supplies.
- **Per Coinsurance Stated Above**

### Telemedicine Consultation Benefit

- **Benefit:** limited to five (5) visits per Policy Year, available through STAT DOCTORS. Go to www.StatDoctors.com or call 877-585-7828.
- **100%**

### Physical Therapy

- **Benefit:** when prescribed by the attending Physician, limited to one (1) visit per day.
- **Per Coinsurance Stated Above**

### Diagnostic X-ray Services

- **Benefit:** when prescribed by a physician.
- **Per Coinsurance Stated Above**

### Laboratory Procedures

- **Benefit:** when prescribed by a Physician.
- **Per Coinsurance Stated Above**

### Prescription Drugs (Rx Card)

- **Benefit:** medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made. **Benefits include:** hypodermic needles or syringes required for the administration of a prescription drug. **Prescriptions must be filled at a Restat Participating Pharmacy, www.restat.com. Co-pays do not apply to generic prescription contraceptives.**
- **Per Coinsurance Stated Above**
  - 100%, after $15 co-pay for generic drugs;
  - $30 co-pay for brand name drugs; or
  - $50 co-pay for preferred brand name drugs

### Hospice Care Coverage

- **Benefit:** when diagnosed with a terminal illness by a licensed Physician. **Medical prognosis must be death within six (6) months.**
- **Per Coinsurance Stated Above**

### Home Health Care Expense

- **Benefit:** when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary.
- **Per Coinsurance Stated Above**, after $50 deductible per Policy Year; up to 40 visits per Policy Year

## OTHER BENEFITS

### Mental Illness Benefit

- **Benefit:** for the diagnosis and treatment of mental disorders, as follows:
  - Biologically-Based Mental Disorders
  - Non-Biologically-Based Mental Disorders, limited to:
    - 60 days of inpatient treatment per Policy Year
    - 24 outpatient visits per Policy Year
  - 100%, same as any other covered condition

### Ambulance Service

- **Benefit:** for transportation to or from a Hospital by ground ambulance.
- **Per Coinsurance Stated Above**

### Durable Medical Equipment

- **Benefit:**
- **Per Coinsurance Stated Above**

### Accidental Injury Dental Treatment

- **Benefit:** as the result of Injury. Routine dental care and treatment are not payable under this benefit.
- **Per Coinsurance Stated Above**

### Sickness Dental Expense

- **Benefit:** treatment for impacted wisdom teeth.
- **Per Coinsurance Stated Above**, subject to a maximum of $350 per tooth

### Maternity Benefit

- **Benefit:** including hospital stays, inpatient Physician or surgeon charges and Physician-directed follow-up care.
- **Same as any other covered condition**

### Routine Newborn Care

- **Benefit:** during the first thirty-one (31) days immediately following the birth.
- **Same as any other covered condition**

### Preventative Services

- **Benefit:** deductible, co-pays and coinsurance do not apply.
- **100%**

### Medical Evacuation Expense

- **Benefit:** for International Students and/or their Dependents and Domestic Student participating in a study abroad program. **100%, not to exceed $25,000 per evacuation**

### Repatriation Expense

- **Benefit:** for International Students and/or their Dependents and Domestic Student participating in a study abroad program. **100%, not to exceed $25,000 per evacuation**
Notice Regarding Translator and Interpretation Services

We provide, upon request, interpreter and translation services related to administrative procedures and claims processing. This service is available to you when you contact our Customer Service Department at 1-800-MED-STOP.