STUDENT BLANKET HEALTH INSURANCE

National Guardian Life Insurance Company, referred to in this Policy as “We,” “Us,” “Our” or “the Company,” issues this Policy to the Policyholder named in the Insurance Information Schedule to insure the students of a School.

INSURING AGREEMENTS

COVERAGE: Benefits are provided to cover the expenses incurred:
1. Due to a Covered Sickness or a Covered Injury; and
2. Sustained while the Policy is in force as hereinafter specifically provided.

We will pay the benefits under the terms of the Policy in consideration of:
1. The application for this Policy; and
2. The payment of all premiums as set forth in the Policy.

The Effective and Termination Dates for coverage under this Policy are as shown in the Schedule of Benefits and Rates. All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

The following pages form a part of this Policy as fully as if the signatures below were on each page.

This Policy is executed for the Company by its President and Secretary.

Kimberly A. Shaul
Secretary

Mark L. Solverud
President

Non-Participating
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NBH-280 (2015) PPO PA
INSURANCE INFORMATION SCHEDULE

POLICYHOLDER: Bucknell University  
Lewisburg, PA

POLICY NUMBER: 2016I5B05

EFFECTIVE DATE: August 1, 2016  
TERMINATION DATE: July 31, 2017

The Policy Year runs from the Policy Effective date until the Policy Termination Date. The Policy Term is the period of time selected by the Insured Student and for which premium has been paid that insurance is effect while an eligible student of the Policyholder.

PREMIUM SCHEDULE

<table>
<thead>
<tr>
<th>CLASS OF INSURED PERSONS</th>
<th>Policy Term</th>
<th>PREMIUM RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Only</td>
<td>Annual</td>
<td>$1,997.00</td>
</tr>
<tr>
<td>Spouse Only</td>
<td>Annual</td>
<td>$1,997.00</td>
</tr>
<tr>
<td>Child(ren) Only</td>
<td>Annual</td>
<td>$1,997.00</td>
</tr>
<tr>
<td>Student Only</td>
<td>Fall</td>
<td>$ 837.00</td>
</tr>
<tr>
<td>Spouse Only</td>
<td>Fall</td>
<td>$ 837.00</td>
</tr>
<tr>
<td>Child(ren) Only</td>
<td>Fall</td>
<td>$ 837.00</td>
</tr>
<tr>
<td>Student Only</td>
<td>Spring/Summer</td>
<td>$1,061.00</td>
</tr>
<tr>
<td>Spouse Only</td>
<td>Spring/Summer</td>
<td>$1,061.00</td>
</tr>
<tr>
<td>Child(ren) Only</td>
<td>Spring/Summer</td>
<td>$1,061.00</td>
</tr>
</tbody>
</table>

CLASSES OF PERSONS

<table>
<thead>
<tr>
<th>ENROLLMENT REQUIREMENTS</th>
<th>ENROLLMENT PERIOD</th>
<th>WAITING PERIOD</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Student</td>
<td>9 or more credit hours</td>
<td>31 Days</td>
</tr>
<tr>
<td>Continuing Student</td>
<td>9 or more credit hours</td>
<td>31 Days</td>
</tr>
<tr>
<td>Graduate Student</td>
<td>9 or more credit hours</td>
<td>31 Days</td>
</tr>
<tr>
<td>Spouse</td>
<td>Student must be enrolled</td>
<td>31 Days</td>
</tr>
<tr>
<td>Child</td>
<td>Student must be enrolled</td>
<td>31 Days</td>
</tr>
</tbody>
</table>

STUDENT CLASSIFICATION

☒ Domestic  ☒ International  □ Scholar  □ Other (Specify)

PARTICIPATION

☒ Voluntary - Dependents  ☒ Waiver - Students  □ Mandatory  □ Other (Specify)
SCHEDULE OF BENEFITS
GOLD PLAN

Benefit Period: When an Insured Person receives initial medical treatment within 30 days of the occurrence of a Covered Injury or at the onset of a Covered Sickness, eligible benefits will be provided for a continuous Benefit Period. The Benefit Period begins:
1. On the date of occurrence of such Covered Injury; or
2. From the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of:
   ☑ the Policy Term (+ Extension of Benefits - when appropriate) ☐ Other

Preventive Services:
Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the Usual and Reasonable charge when services are provided through a Network Provider.

Non-Network: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum.

Deductible: Network $250.00
Non-Network $500.00

Out-of-Pocket Expense Limit: Network Provider: Individual $6,600.00
Family $13,200.00
Non-Network Provider: Individual $6,600.00
Family/No maximum

Coinsurance Amount:
Network Provider: 80% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider: 60% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.

Benefit Payment for Network Providers and Non-Network Providers
This policy provides benefits based on the type of health care provider selected. This Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

PREFERRED PROVIDER ORGANIZATION:
To locate a Cigna Provider in Your area, consult Your Provider Directory or call toll free 800-633-7867 or visit Our website at www.chpstudent.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.
<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital Room &amp; Board Expenses</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room &amp; Board Expenses</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses for services &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Physician’s Visits while Confined: Limited to one per day of Confinement</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Inpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Skilled Nursing Facility Expense Benefit Up to 120 days per Policy Year</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
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</tr>
<tr>
<td><strong>Outpatient Benefits</strong></td>
<td></td>
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</tr>
<tr>
<td>Outpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>The PPO Allowance stated above Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>The PPO Allowance stated above Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>The PPO Allowance stated above Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Outpatient Surgery Miscellaneous</td>
<td>The PPO Allowance stated above Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>(excluding not-scheduled surgery)</td>
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<td></td>
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</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td>The PPO Allowance stated above Copayment: $20.00 Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>including cardiac rehabilitation,</td>
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<tr>
<td>pulmonary rehabilitation, physical</td>
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<tr>
<td>therapy, occupational therapy and</td>
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<tr>
<td>speech therapy</td>
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<tr>
<td>Physical Therapy and</td>
<td></td>
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<tr>
<td>Occupational therapy subject</td>
<td></td>
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<tr>
<td>to combined limit of 365 visits</td>
<td></td>
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<tr>
<td>per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy limited to 365</td>
<td>The PPO Allowance stated above Copayment: $20.00 Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>visits per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habilitative Services are</td>
<td>The PPO Allowance stated above Copayment: $20.00 Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>covered to the extent that they</td>
<td></td>
<td></td>
</tr>
<tr>
<td>are Medically Necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services Expenses</td>
<td>80% of PPO Allowance for Covered Medical Expenses Deductible Waived if Student Health Center Referred</td>
<td>80% of PPO Allowance for Covered Medical Expenses Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
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<tr>
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</tr>
<tr>
<td><strong>Outpatient Benefits</strong> (continued)</td>
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<td></td>
</tr>
<tr>
<td><strong>In Office Physician’s Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The PPO Allowance stated above</td>
<td></td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Deductible Waived if Student Health Center Referred</td>
<td></td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td><strong>Diagnostic X-ray Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The PPO Allowance stated above</td>
<td></td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Deductible Waived if Student Health Center Referred</td>
<td></td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td><strong>Laboratory Procedures</strong> (Outpatient)</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Deductible Waived if Student Health Center Referred</td>
<td>The Usual and Reasonable Charge stated above</td>
<td></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Copayment: $15.00 Generic Brand</td>
<td>Copayment: $15.00 Generic Brand</td>
<td></td>
</tr>
<tr>
<td>Copayment: $35.00 Preferred Brand</td>
<td>Copayment: $35.00 Preferred Brand</td>
<td></td>
</tr>
<tr>
<td>Copayment: $75.00 Brand</td>
<td>Copayment: $75.00 Brand</td>
<td></td>
</tr>
<tr>
<td>See Prescription Card</td>
<td>(Paid on a reimbursement basis)</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Deductible Waived if Student Health Center Referred</td>
<td>Deductible Waived if Student Health Center Referred</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care Expenses</strong> Up to 60 visits per Policy Year</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Hospice Care Coverage</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Other Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Service ground and/or air transportation</strong></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Braces and Appliances</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The PPO Allowance stated above</td>
<td></td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The PPO Allowance stated above</td>
<td></td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td><strong>Maternity Benefit</strong></td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td><strong>Routine Newborn Care</strong></td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
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<td>-------------------------------------</td>
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</tr>
<tr>
<td><strong>Other Benefits (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Dental Care Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Dental Care – limited to 1 dental exams every 6 months</td>
<td>See Benefit for limitations</td>
<td>See Benefit for limitations</td>
</tr>
<tr>
<td></td>
<td>100% of PPO Allowance for Preventive Services</td>
<td>85% of Usual and Reasonable Charge for Preventive Services</td>
</tr>
<tr>
<td></td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
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<td></td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
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<td>50% Usual and Reasonable</td>
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<td></td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td></td>
<td>85% of Usual and Reasonable Charge</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Pediatric Vision Care Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames</td>
<td>100% of PPO Allowance for Covered Medical Expenses for Preventive Services</td>
<td>60% of Usual and Reasonable Charge for Covered Medical Expenses for Preventive Services</td>
</tr>
<tr>
<td>Adult Vision Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Eye Exam once every 24 months</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived if Student Health Center Referred</td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Chiropractic Care Benefit</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td></td>
<td>Copayment: $20.00</td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived if Student Health Center Referred</td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Consultant/Specialist Physician Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived if Student Health Center Referred</td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Covered Clinical Trials</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment for Insured Person’s over age 18</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived if Student Health Center Referred</td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Student Health Center/Infirmary Expense</td>
<td>The Usual and Reasonable Charge stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived</td>
<td>Deductible Waived</td>
</tr>
<tr>
<td>Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate, intramural or club sports</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td></td>
<td>Deductible Waived if Student Health Center Referred</td>
<td>Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td><strong>BENEFITS PER COVERED INJURY/SICKNESS</strong></td>
<td><strong>IN-NETWORK</strong></td>
<td><strong>NON-NETWORK</strong></td>
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<tr>
<td>----------------------------------------</td>
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</tr>
<tr>
<td><strong>Other Benefits (continued)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Evacuation Expense</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>Repatriation Expense</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td><strong>Mandated Benefits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mastectomy and Reconstructive Surgery Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Treatment and Self-Management of Diabetes</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Colorectal Cancer Screening</td>
<td>Same as any other Preventive Service</td>
<td></td>
</tr>
<tr>
<td>Mammmography examinations</td>
<td>Same as any other Preventive Service</td>
<td></td>
</tr>
<tr>
<td>Annual Gynecological and Routine Pap Smears</td>
<td>Same as any other Preventive Service</td>
<td></td>
</tr>
<tr>
<td>Cancer Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Coverage for Cost of Nutritional Supplements Benefits – Medical Foods</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Dental Anesthesia for Children and Developmentally Disabled Insured Persons</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
<tr>
<td>Child Immunizations Benefit</td>
<td>Same as any other Preventive Service</td>
<td></td>
</tr>
<tr>
<td>Medical Foods (Enteral Formulas) Benefit</td>
<td>Same as any other Covered Sickness, subject to the limitations described in the Benefit</td>
<td></td>
</tr>
</tbody>
</table>
SECTION I - ELIGIBILITY AND PARTICIPATION BASIS

Students of the Policyholder are eligible for coverage under one of the following bases. The Insurance Information Schedule will indicate who is eligible for coverage, on what basis and enrollment requirements.

1. **Voluntary Participation** - All individuals shown on the Insurance Information Schedule are eligible for Accident and Sickness insurance on a Voluntary Participation basis.

2. **Waiver Participation** - All individuals shown on the Insurance Information Schedule are eligible for insurance on a Waiver Participation Basis.

3. **International Students and/or Visiting Faculty Member** - All such individuals are eligible for this plan on a Waiver Participation Basis. All eligible International Students and/or Visiting Faculty must have and maintain a current passport and a proper student Visa (either an F-1, J-1 or M-1 category Visa).

4. **Dependent Coverage** - Eligible individuals may also insure, on a Voluntary Participation Basis, their eligible Dependents. Individuals who enroll their dependents must enroll them within thirty-one (31) days of the Insured Student’s enrollment in the plan with the exception of adopted children or newborn children (see the provision entitled Dependent Child Coverage). Dependents will be enrolled for the same term of coverage for which the Insured Student enrolls. Dependents of an Eligible International Student must possess a valid passport and a proper visa (either an F-2, J-2 or M-2 visa).

**Waiver Participation Basis** means that enrollment for insurance is required of all eligible persons except those who have submitted evidence of equivalent coverage satisfactory to the Policyholder.

**Voluntary Participation** means that only those eligible persons who have:
1. Executed Our enrollment form; and
2. Paid the required premium
are insured under this Policy.

To be eligible for coverage under this Policy, a student must:
1. Meet the enrollment requirements stated in the Insurance Information Schedule; and
2. Pay the required premium; and
3. Attend classes for at least the first 31 days of the period for which premium has been paid.

We maintain the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that they have not been met, Our only obligation is to refund premium.

SECTION II - POLICY YEAR, PREMIUM AND PREMIUM PAYMENT

**Policy Year:** This Policy takes effect and terminates on the corresponding dates shown in the Insurance Information Schedule. All time periods begin and end at 12:01 A.M., local time, at the address of the Policyholder.

**Premium and Premium Payment:** Premium for the Policy will be calculated on the basis of the rates stated in the Premium Schedule.

The Policyholder agrees to submit to Us or Our duly authorized agent the name, effective date and any other required eligibility information for each person becoming insured hereunder. This must be done within 30 days after the effective date of each Insured Person's coverage. The information, together with payment of the premium due for such persons, must be submitted.
If We or Our duly authorized agent do not receive this information within this 30 day period, coverage on any names submitted subsequent to that period will not take effect until the date We actually receive the name of the person to be insured. Coverage is also subject to payment of any premium due.

**Refund of Premium:** 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.
3. For International Students, Scholars, Visiting Faculty member and/or their covered Dependents. We will refund a pro rata portion of the premium actually paid for any individual who:
   a. Withdraws from School during his/her first semester; and
   b. Returns to his/her Home Country.
A written request must be sent to us within 60 days of such departure.

No other refunds will be allowed.

**SECTION III - EFFECTIVE AND TERMINATION DATES**

**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;
4. The day after the date of postmark if the Enrollment Form is mailed; or
5. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be no more than 48 hours later than the departure from the Home Country.

Dependent’s coverage, under the Voluntary Participation Basis, becomes effective on the later of:
1. The day after the date of postmark when the Enrollment Form is mailed; or
2. The beginning date of the term for which premium has been paid; or
3. The day after the date the required individual Enrollment Form and premium payment are received by Us or Our authorized agent. This applies only when premium payment is made within 31 days of the student’s enrollment in the School’s insurance plan; or
4. The Policy effective date.

The last date for enrollment is shown in the Insurance Information Schedule. The Enrollment Period will run from the start of the quarter or semester for which coverage is desired.

**Termination Dates:** An Insured Person’s insurance will terminate on the earliest of:
1. The date this 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; or
5. For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks);
6. For International Students, the date the student ceases to meet Visa requirements;
7. On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error.
Dependent Child Coverage

Newly Born Children - A newly born child of an Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth.
To continue coverage beyond this initial 31-day period, the Insured Person must:
1. Notify Us of the birth; and
2. Pay any additional premium.

Adopted Children and Foster Children - Dependent Child Coverage also applies to any child under age 18 adopted or placed for adoption irrespective of whether the adoption has become final or placed as a foster child with the Insured Student. If an additional premium is required, We must receive:
1. Notification of a child’s placement for adoption or placement for foster care within 31 days of the placement; and
2. Any premium required for the child.

If no additional; premium is required, We recommend that the Insured Student notify of the placement or adoption to ensure proper claims adjudication. We will provide coverage for the child placed for adoption as long as the Insured Person:
1. Has custody of the child;
2. The Insured Student’s coverage under this policy remains in effect; and
3. The required premiums are furnished to Us.

As it pertains to this provision:

Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child’s placement with a person terminates upon the termination of the legal obligation.

Handicapped Children: If:
1. There is dependent coverage; and
2. The Policy provides that coverage of a dependent child will terminate upon attainment of a specified age.
We will not terminate the coverage of such child due attainment of that age while the child is and continues to be both:
1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
2. Chiefly dependent upon the Insured Student for support and maintenance.

Proof of such incapacity and dependence shall be furnished to us within thirty-one days of the child's attainment of the limiting age. Upon request, We may require proof satisfactory to it of the continuance of such incapacity and dependency. We may not request this more frequently than annually after the two-year period following the child's attainment of the limiting age.

Extension of Benefits: Coverage under this Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows:
1. 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 90 days from the Termination Date while such confinement continues.
Continuous Coverage: Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under this Policy:
1. When premium payment is received either in Our Home Office or by Our Agent or the Plan Administrator; and
2. Premium is received within the Enrollment Period specified in the Insurance Information Schedule.

This is regardless of any breaks in calendar days between consecutive periods of insurance.

SECTION IV – DEFINITIONS

These are key words used in this Policy. They are used to describe the Policyholder’s rights as well as Ours. Reference should be made to these words as the Policy is read.

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

Ambulance Service means transportation to a Hospital by an Ambulance Service.

Anesthetist means a Physician or nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Autism Spectrum Disorder means conditions that effect neurodevelopmental growth and defined as Pervasive Developmental Disorders in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association. This includes Aspergerger’s Syndrome.

Brand Name Drugs means drugs for which the drug manufacturer’s trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

Coinsurance means the ratio by which We and the Insured Person share in the payment of Usual and Reasonable expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Copayment 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 Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:
1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.
**Covered Clinical Trials** means phase I, II, phase III, and phase IV patient research studies designed to evaluate new treatments, including prescription drugs, and that:
1. Involve the treatment of life-threatening medical conditions,
2. Are medically indicated and preferable for that patient compared to available non-investigational treatment alternatives, and
3. Have clinical and preclinical data that shows the trial will likely be more effective for that patient than available non-investigational alternatives.

Covered Clinical Trials must also meet the following requirements:
1. Must involve determinations by treating Physicians, relevant scientific data, and opinions of experts in relevant
2. Must be trials approved by centers or cooperative groups that are funded by the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, the Agency for Health Care Research and Quality, the Department of Defense, or the Department of Veterans Affairs. The health benefit plan may also cover clinical trials sponsored by other entities.
3. Must be conducted in a setting and by personnel that maintain a high level of expertise because of their training, experience, and volume of patients.

**Covered Injury** means a bodily injury that is:
1. Sustained by an Insured Person while he/she is insured under this Policy or the School’s prior policies; and
2. Caused by an 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 this 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 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.

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

**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 (annual or per occurrence) will be shown in the Schedule of Benefits.

**Dependent** means:
1. An Insured Student’s lawful spouse or lawful Domestic Partner;
2. An Insured Student’s dependent biological or adopted child, child placed for adoption, foster or stepchild or a child covered due to a court or an administrative order, under age 26; and
3. An Insured Student’s unmarried biological or adopted child or stepchild who has reached age 26 and who is:
   a. primarily dependent upon the Insured Student for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

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 an Insured Student enrolls a new disabled child under the plan.

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**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, tubal ligation, 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.

**Eligible Student** means a student who meets all enrollment requirements of the School named as the Policyholder in the Insurance Information Schedule.

**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.

**Emergency Services** means, with respect to an Emergency Medical Condition: transportation services, including but not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

**Essential Health Benefits** means benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

**Formulary** means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

**Generic Drugs** means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.
**Home Country** means the Insured Student’s country of citizenship. If the Insured Student has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the United States. The Insured Student’s Home Country is considered the Home Country for any dependent of an Insured Student while insured under this Policy.

**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
5. Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

Hospital does not include the following:
1. Convalescent homes or convalescent, rest or nursing facilities;
2. Facilities primarily affording custodial, educational, or rehabilitory care; or
3. Facilities for the aged.

**Hospital Confined or Hospital Confinement** means a stay of eighteen (18) or more consecutive hours as a resident bed patient in a Hospital.

**Immediate Family Member** means the Insured Person and his or her spouse or the parent, child, brother or sister of the Insured Person or his or her spouse.

**Insured Person** means an Insured Student or dependent of an Insured Student while insured under this Policy.

**Insured Student** means a student of the Policyholder who is eligible and insured for coverage under this Policy.

**International Student** means an international student:
1. With a current passport and a student Visa;
2. Who is temporarily residing outside of his or her Home Country; and
3. Is actively engaged, on a full time basis, as a student or in educational research activities through the Policyholder.

In so far as this Policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

**Loss** means medical expense caused by an Injury or Sickness which is covered by this Policy.

**Medically Necessary** means medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. The Insured Person’s health care provider determines if the medical treatment provided is Medically Necessary.

**Mental Health Disorder** means a condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Network Providers** are Physicians, Hospitals and other health care providers who have contracted with Us to provide specific medical care at negotiated prices.

**Non-Network Providers** have not agreed to any pre-arranged fee schedules.
Non-Preferred Brand Drugs means drugs that have a higher copayment and have recently come on the market. In most cases, an alternative preferred medication is available. If a physician prescribes a brand-name drug when a generic equivalent is available, you must pay the difference in cost in addition to a copayment.

Out-of-Pocket Expense Limit means the amount of Usual and Reasonable expenses that an Insured Person is responsible for paying.

Physical Therapy, means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part.

Physician means a:
1. Doctor of Medicine (M.D.); or
2. Doctor of Osteopathy (D.O.); or
3. Doctor of Dentistry (D.M.D. or D.D.S.); or
4. Doctor of Chiropractic (D.C.); or
5. Doctor of Optometry (O.D.); or
6. Doctor of Podiatry (D.P.M.);
   who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered.

A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a “Physician.” This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician’s assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician.

The term Physician does not mean any person who is an Immediate Family Member.

PPO Allowance means the amount a Network Provider will accept as payment in full for Covered Medical Expenses.

Preferred Brand Drug means a formulary drug that is within a select subset of therapeutic classes, which make up the formulary drug list.

School or College means the college or university attended by the Insured Student.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

Skilled Nursing Facility means an institution that provides skilled nursing care under the supervision of the individual from a facility.

Student Health Center or Student Infirmary means an on campus facility that provides:
1. Medical care and treatment to Sick or Injury students; and
2. Nursing services.

A Student Health Center or Student Infirmary does not include:
1. Medical, diagnostic and treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care.
**Substance Use Disorder** means any condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Treatment** means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

**Usual and Reasonable** means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for:
1. Like service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.

**Visa,** in so far as this Policy is concerned, means the document issued by the United States Government that permits an individual to participate in the educational activities of a college, university or other institution of higher learning either as a student or in another academic capacity. An International Student must have and maintain a valid visa, either an F-1 (Academic), J-1 (Exchange) or M-1 (Vocational) in order to continue as a student in the United States.

**We, Us, or Our** means National Guardian Life Insurance Company or its authorized agent.

**SECTION V - DESCRIPTION OF BENEFITS**

**Benefit Payments**

**Preventive Services**
The following services shall be covered without regard to any Deductible or Coinsurance requirement that would otherwise apply:
1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force and includes:
   a. Screening for tobacco use; and,
   b. For those who use tobacco products, at least two tobacco cessation attempts per year. For this purpose, covering a cessation attempt includes coverage for:
      i. Four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization and
      ii. All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved.
3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

**Essential Health Benefits**
These benefits are not subject to annual or lifetime dollar limits. If additional specific care, treatment or services are added to the list of Essential Health Benefits by a governing authority, the Policy benefits will be amended to comply with such changes.
Treatment of Covered Injury or Covered Sickness:
We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to a Covered Injury or Covered Sickness. Benefits payable are subject to:
1. Any specified benefit maximum amounts;
2. Any Deductible amounts;
3. Any Coinsurance amount;
4. Any Copayments;
5. The Maximum Out-of-Pocket Expense Limit; and
6. Use of a Network Provider, if any.

The following are shown in the Schedule of Benefits:
- Deductible
- Any specified benefit maximums
- Coinsurance percentages
- Copayment amounts
- Out-of-Pocket Expense Limits

The Covered Medical Expenses for an issued Policy will be only those listed in Covered Medical Expenses with all applicable Deductibles, Coinsurance and Copayment amounts, and maximums for each benefit shown in the Schedule of Benefits.

The total benefit payable for all Covered Medical Expenses resulting from Covered Injuries and Covered Sicknesses will never exceed the Maximum Benefit shown in the Schedule of Benefits. We will not pay for expenses incurred that do not meet the definition of Covered Medical Expense.

Benefit Period
The first treatment of a Covered Injury or Covered Sickness must begin within the time stated in the Benefit Period shown in the Schedule of Benefits. A Benefit Period begins when the Insured Person experiences a Loss due to Covered Injury or Covered Sickness. The Benefit Period terminates at the end of the period defined in the Schedule of Benefits. Any extension of a Benefit Period, if provided elsewhere in this Policy, is limited to medical treatment of the Covered Injury or Covered Sickness that is ongoing on the termination date of the Insured Person’s coverage. The Insured Person’s termination date of coverage as it would apply to any other Covered Injury or Covered Sickness will not be affected by such extension.

Preferred Provider Organization
If an Insured Person uses a Network Provider, this Policy will pay the Coinsurance percentage of the PPO Allowance shown in the Schedule of Benefits for Covered Medical Expenses.

If a Non-Network Provider is used, this Policy will pay the percentage of the Usual and Reasonable Covered Medical Expense shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be the responsibility of the Insured Person.

Note however, that We will at the PPO Allowance level for treatment by a Non-Network Provider if:
1. There is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. There is an Emergency Medical Condition and the Insured Person cannot reasonably reach a network Provider. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.
An Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers. Receiving services from a Network Provider does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Physicians are Network Providers each time he or she calls for an appointment or at the time of service.

**Out-of-Pocket Expense Limit**
The Out-of-Pocket Expense Limit is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person’s Coinsurance amounts, Deductibles and Copays will apply toward the Out-of-Pocket Expense Limit.

**Basic Injury and Sickness Benefit**
If:
1. an Insured Person incurs expenses as the result of Covered Injury or Covered Sickness, then
2. We will pay the benefits stated in the Schedule of Benefits for the services, treatments and supplies described in the Covered Medical Expenses provision below.

Payment will be made, Subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits:

1. For the Usual and Reasonable Charges for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

**Covered Medical Expenses**

We will pay the Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness. The Covered Medical Expenses for an issued Policy will be only those listed below and as shown in the Schedule of Benefits.

**Inpatient Benefits**

1. **Hospital Room and Board Expense**, including general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed.

2. **Hospital Intensive Care Unit**, including 24-hour nursing care. This benefit is NOT payable in addition to room and board charges incurred on the same date.

3. **Hospital Miscellaneous Expenses**, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
   a. The cost for use of an operating room;
   b. Prescribed medicines;
   c. Laboratory tests;
   d. Therapeutic services, for services administered with the expectation that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. This coverage includes Physical Therapy, Inpatient Rehabilitation, Occupational Therapy and Speech Therapy when services rendered are part of an inpatient plan of treatment under the direction of the attending Physician;
   e. X-ray examinations;
   f. Casts and temporary surgical appliances;
   g. Oxygen, oxygen tent;
   h. Blood and blood plasma; and
   i. Miscellaneous supplies.
4. **Preadmission Testing** for routine tests performed as a preliminary to the Insured Person’s being admitted to a Hospital. These tests must be performed within three working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI’s, NMR’s, and blood chemistries.

5. **Physician’s Visits while Confined** not to exceed one visit per day. Physician’s visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon’s fees are not payable under this benefit.

6. **Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician’s visits.

7. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for custodial care or residential care is not covered.

### Outpatient Benefits

1. **Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** for outpatient surgery (including fees for pre- and post-operative visits) as specified in the Schedule of Benefits. COVERED surgical expenses will be paid under either the outpatient surgery benefit or the inpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value.

2. **Outpatient Surgery Miscellaneous** (excluding non-scheduled surgery) surgery performed in a hospital emergency room, trauma center, physician’s office, outpatient or ambulatory surgical center or clinic. Benefits will be paid for services and supplies, including:
   a. Operating room;
   b. Therapeutic services;
   c. Oxygen, oxygen tent;
   d. Blood and blood products and administration; and
   e. Miscellaneous supplies.

3. **Rehabilitation Therapy** - when prescribed by the attending Physician, We will pay the Usual and Reasonable expenses for Rehabilitation Therapy services. Rehabilitation Therapy means services administered with the expectation that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. This is a form of rehabilitation therapy in which patients travel to a clinic, hospital, or other facility specifically to attend sessions and then leave, rather than remaining hospitalized for the duration of their therapy.

   This benefit includes Occupational Therapy, Physical Therapy and Speech Therapy, subject to the limits shown in the Schedule of Benefits.

4. **Habilitative Services** - when prescribed by the attending Physician, We will pay the expenses incurred for Habilitative Services expenses incurred for medically appropriate and necessary services that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Habilitative Services are provide the same services and under the same terms and conditions as the Rehabilitation Therapy benefit.
5. **Emergency Services Expenses** only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, urgent care center, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

6. **In Office Physician’s Visits** for Physician’s office visits. We will not pay for more than one visit per day. Physician’s Visit benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

7. **Diagnostic X-ray Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a physician.

8. **Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

9. **Prescription Drugs** for medication for which a Physician’s written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made.
   a. **Off-Label Drug Treatments** - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
      1) The drug is approved by the FDA;
      2) The drug is prescribed for the treatment of a life-threatening condition;
      3) The drug has been recognized for treatment of that condition by one of the following:
         (a) The American Medical Association Drug Evaluations;
         (b) The American Hospital Formulary Service Drug Information.
         (c) The United State Pharmacopoeia Dispensing Information, volume 1, “Drug Information for Health Care Professionals”;
         (d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

   When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items 1), 2), and 3) of this benefit.
   As it pertains to this benefit, life threatening means either or both of the following:
   (a) Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
   (b) Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

   b. **Step Therapy** - When medications for the treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us within forty-eight (48) hours, if all necessary information to perform the override review has been provided, under the following documented circumstances:
      1) The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first protocol has been ineffective in the treatment of the Insured Person's disease or medical condition; or
      2) Based on sound clinical evidence or medical and scientific evidence:
         (a) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or
(b) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the Insured Person.

The duration of any step therapy or fail-first protocol shall not be longer than a period of thirty (30) days if the treatment is deemed and documented as clinically ineffective by the prescribing practitioner. When the prescribing practitioner can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief or an amelioration to the insured, the step therapy or fail-first protocol may be extended up to seven (7) additional days.

c. Specialty Drugs - “Specialty Drugs” are Prescription Drugs which:
   1) Are only approved to treat limited patient populations, indications, or conditions; or
   2) Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or
   3) Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

10. Outpatient Miscellaneous Expenses (Excluding surgery) for miscellaneous outpatient expenses (excluding surgery) incurred for the treatment and care of a Covered Injury or Covered Sickness. Expenses must be incurred on the advice of a Physician. Miscellaneous outpatient expenses include other reasonable expenses for services and supplies that have been prescribed by the attending Physician.

11. Home Health Care Expense for Home Health Care for an Insured Person for up to 60 visits per Benefit Year when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary.

12. Hospice Care Coverage when, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare. Precertification required for out-of-network care. Benefits will be reduced by 50% per service or supply if precertification is not obtained.

As used in this benefit:
Hospice Care means a coordinated program of home and inpatient care provided directly or under the direction of a properly licensed Hospice. Such services will include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medical directed interdisciplinary team.

Palliative care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he or she experiences the stress of the dying process, rather than at treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.
Other Benefits

1. **Ambulance Service** for transportation to or from a Hospital by ground and air ambulance.

2. **Braces and Appliances** when prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We will also not pay for braces and appliances used as protective devices during a student’s participation in sports. Replacement braces and appliances are not covered.

3. **Durable Medical Equipment** for the rental or purchase of durable medical equipment, including, but not limited to, Hospital beds, wheel chairs, and walkers. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable medical equipment must:
   a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
   b. Be able to withstand repeated use; and
   c. Generally not be useful to a person in the absence of Injury or Sickness.

4. **Maternity Benefit** - We will pay the expenses incurred for maternity charges as follows:
   a. Routine prenatal care
   b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness.

   Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.
   c. **Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.
   d. **Physician-directed Follow-up Care** including:
      1) Physician assessment of the mother and newborn;
      2) Parent education;
      3) Assistance and training in breast or bottle feeding;
      4) Assessment of the home support system;
      5) Performance of any prescribed clinical tests; and
      6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

   This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item “a”, the home health care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn.
   e. **Outpatient Physician’s visits** will be covered the same as for any other Covered Sickness.
5. **Routine Newborn Care** – when expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:
   a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   b. Inpatient Physician visits for routine examinations and evaluations;
   c. Charges made by a Physician in connection with a circumcision;
   d. Routine laboratory tests;
   e. Postpartum home visits prescribed for a newborn;
   f. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and
   g. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the treatment of such newly born child. The benefit payable for transportation will not exceed the Usual and Reasonable charges.

6. **Pediatric Dental Care Benefit:** We will pay the Usual and Reasonable expenses incurred for Routine Dental Care for Dependent Children up to age 19. Dental Care for Insured Students and Dependent Children up to age 19.
   a. Emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.
   b. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
      1) Prophylaxis (scaling and polishing the teeth at six (6) month intervals);
      2) Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
      3) Sealants on unrestored permanent molar teeth; and
      4) Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.
   c. Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:
      1) Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
      2) X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
      3) Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
      4) In-office conscious sedation;
      5) Amalgam, composite restorations and stainless steel crowns; and
      6) Other restorative materials appropriate for children.
   d. Endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.
      1) Prosthodontic services as follows:
      2) Removable complete or partial dentures, including six (6) months follow-up care; and
      3) Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:
1) For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
2) For cleft palate stabilization; or
3) Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.
e. Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

1) Procedures include but are not limited to:
2) Rapid Palatal Expansion (RPE);
3) Placement of component parts (e.g. brackets, bands);
4) Interceptive orthodontic treatment;
5) Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
6) Removable appliance therapy; and
7) Orthodontic retention (removal of appliances, construction and placement of retainers).

7. **Pediatric Vision Care Benefit** for Insured Persons who are age 19 and under. We will provide benefits for:
   a. One vision examination per Policy Year; and
   b. One pair of prescription and eyeglass frames every Policy Year.

   1) Vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:
      a) Case history;
      b) External examination of the eye or internal examination of the eye;
      c) Ophthalmoscopic exam;
      d) Determination of refractive status;
      e) Binocular distance;
      f) Tonometry tests for glaucoma;
      g) Gross visual fields and color vision testing; and
      h) Summary findings and recommendation for corrective lenses.

8. **Prescription lenses or contact lenses** once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic and includes treatment of Aphakia. We also cover standard frames adequate to hold lenses once in any twelve (12) month period, unless it is Medically Necessary for an Insured Person to have new frames more frequently, as evidenced by appropriate documentation.

9. **Adult Vision Care** means examinations for the purpose of determining the need for corrective lenses, and if needed to provide a prescription for corrective lenses. We will cover one vision examination in any twenty-four (24) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. Benefits include charges for a complete eye exam that includes refraction.

For prescribed Lenses & Frames we will pay for standard prescription lenses or contact lenses once in any twelve (12) month period.

10. **Chiropractic Care Benefit** for Chiropractic Care are subject to the limit provided in the Schedule of Benefits. We cover chiropractic care when performed by a Doctor of Chiropractic (“Chiropractor”) or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities.

11. **Consultant/Specialist Physician Services** - When requested and approved by the attending Physician.
12. **Covered Clinical Trials** for Medically Necessary expenses incurred in connection with health care services for an Insured Person are reimbursed at Usual and Reasonable charges. Benefits do not include the costs of services that are not health care services, those provided solely to satisfy data collection and analysis needs, those related to investigational drugs and devices, and those that are not provided for the direct clinical management of the Insured Person. In the event a claim contains charges related to services for which coverage is required under this Benefit and those charges have not been or cannot be separated from costs related to services for which coverage is not required under this Benefit, We may deny the claim.

We will also pay for Cancer Clinical Trials the same as any other Covered Sickness for all routine patient care costs related to the clinical trial diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer. For purposes of this section, a clinical trial's endpoints shall not be defined exclusively to test toxicity, but shall have a therapeutic intent.

For purposes of this benefit, “Routine patient care costs” means the costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program.

13. **Accidental Injury Dental Treatment** - As the result of Injury. Routine dental care and treatment are not payable under this benefit.

14. **Student Health Center/Infirmary Expense Benefit** - If an Insured Student incurs expenses as the result of treatment at a Student Health Center/Infirmary, we will pay the expenses incurred. Benefits will not to exceed the amount shown in the Schedule of Benefits.

15. **Sports Accident Expense Benefit** for an Insured Student as the result of covered sports accident while at play or practice of intercollegiate, intramural or club sports as shown in the Schedule of Benefits.

16. **Medical Evacuation and Repatriation** - 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:

a. an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness;

b. 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:

a. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five or more consecutive days immediately prior to medical evacuation;

b. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;

c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;

d. 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 31 days after the date of termination;

e. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and

f. 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.

**Mandated Benefits**

**Mandate Disclaimer**: 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.

**Mastectomy and Reconstructive Surgery Benefit** for inpatient care following a Mastectomy for the length of stay that the treating Physician determines is necessary to meet generally accepted criteria for safe discharge. We will also provide coverage for a home health care visit that the treating Physician determines is necessary within forty-eight (48) hours after discharge when the discharge occurs within forty-eight (48) hours following admission for the Mastectomy. We will also provide coverage for Prosthetic Devices; physical complications including lymphedemas; and Reconstructive Surgery incident to any Mastectomy in a manner determined in consultation with the attending Physician and the Insured Person.

**Mastectomy** means the removal of all or part of the breast for Medically Necessary reasons, as determined by a Physician.

**Prosthetic Devices** means the use of initial and subsequent artificial devices to replace the removed breast or portions thereof, pursuant to an order of the Insured Person’s Physician.

**Reconstructive Surgery** means a surgical procedure performed on one breast or both breasts following a mastectomy, as determined by the treating Physician, to reestablish Symmetry Between Breasts or alleviate functional impairment caused by the mastectomy. The term Reconstructive Surgery shall include, but is not limited to, augmentation mammoplasty, reduction mammoplasty and mastopexy.

**Symmetry Between Breasts** means approximate equality in size and shape of the non-diseased breast with the diseased breast after definitive Reconstructive Surgery on the diseased or non-diseased breast has been performed.

**Treatment and Self-Management of Diabetes Benefit** for the equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes if prescribed by a Physician.

Equipment and supplies shall include the following: blood glucose monitors, monitor supplies, insulin, injection aids, syringes, insulin infusion devices, pharmacological agents for controlling blood sugar and orthotics.
Diabetes outpatient self-management training and education shall be provided under the supervision of a Physician with expertise in diabetes to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetes, including information on proper diets. Coverage for self-management education and education relating to diet and prescribed by a Physician shall include:

1. visits medically necessary upon the diagnosis of diabetes;
2. visits under circumstances whereby a Physician identifies or diagnoses a significant change in the patient's symptoms or conditions that necessitates changes in a patient's self-management; and
3. where a new medication or therapeutic process relating to the person's treatment and/or management of diabetes has been identified as medically necessary by a licensed Physician.

Colorectal Cancer Screening

Mammography examinations

Annual Gynecological and Routine Pap Smears

**Cancer Benefits** for cancer chemotherapy and cancer hormone treatments, whether performed in a Physician's office, in an outpatient department of a Hospital, in a Hospital as a Hospital inpatient or in any other medically appropriate treatment setting on the same basis as benefits for cancer chemotherapy and cancer hormone treatments and services which have been approved by the United States Food and Drug Administration for general use in treatment of cancer.

**Coverage for Cost of Nutritional Supplements Benefits** for the cost of nutritional supplements (formulas) as Medically Necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Physician. There is no Deductible imposed for this Benefit.

**Dental Anesthesia for Children and Developmentally Disabled Insured Persons** for General Anesthesia and Associated Medical Costs provided to an Eligible Dental Patient for Dental Care. This Benefit does not cover Dental Care for which general anesthesia is provided nor does it cover general anesthesia for Dental Care rendered for temporal mandibular joint disorders.

For purposes of this benefit:

**Associated Medical Costs** means hospitalization and all related medical expenses normally incurred as a result of the administration of General Anesthesia.

**Dental Care** means the diagnosis, treatment planning and implementation of services directed at the prevention and treatment of diseases, conditions and dysfunctions relating to the oral cavity and its associated structures and their impact upon the human body or the implementation of professional dental care provided to dental patients by a legally qualified dentist or Physician operating within the scope of the dentist's or Physician's training and licensure.

**Eligible Dental Patient** means an Insured Person who is seven (7) years of age or younger or developmentally disabled for whom a successful result cannot be expected for treatment under local anesthesia and for whom a superior result can be expected for treatment under General Anesthesia.

**General Anesthesia** means a controlled state of unconsciousness, including deep sedation, that is produced by a pharmacologic method, a nonpharmacologic method or a combination of both and that is accompanied by a complete or partial loss of protective reflexes that include the Insured Person's inability to maintain an airway independently and to respond purposefully to physical stimulation or verbal command.
**Child Immunizations Benefit:** When Dependent coverage is a part of this policy, We will pay the expenses incurred for childhood immunizations and for medically necessary booster doses of all immunizing agents used in child immunizations.

As used in this benefit, child immunizations, including the immunizing agent, reimbursement for which will not exceed 150% of the average wholesale price, which, as determined by the Pennsylvania Department of Health, conform with the standards of the Advisory Committee on Immunization Practices of the Center For Disease Control, the United States Department of Health and Human Services. Benefits for such immunizations will be exempt from any deductible requirements or specific benefit limitations, subject to any Aggregate Lifetime Maximum Benefit or Policy Maximums.

Benefits for such immunizations will be exempt from any deductible requirements or specific benefit limitations, subject to any Aggregate Lifetime Maximum Benefit or Policy Maximums.

**Medical Foods (Enteral Formulas) Benefit**

For the treatment of inherited metabolic diseases on the same basis as any other Covered Sickness, except that any deductible provisions will not apply to the enteral formulas portion of this benefit. Inherited metabolic diseases include those characterized by deficient metabolism or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat, including phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. Such treatment will include the enteral formulas and special food products that are part of a diet prescribed by a licensed Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. Such diet must be deemed Medically Necessary to avert the development of serious physical and mental disabilities or to promote normal development or function as a consequence of an inherited metabolic disease. We will provide coverage for this benefit only to the extent that the cost of Medically Necessary formulas and special food products exceeds the cost of a normal diet.

For the purposes of this benefit, the following definitions will apply:

**Enteral formula** means an enteral product or enteral products for use at home that are prescribed by a Physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments as being Medically Necessary for the treatment of an inherited metabolic disease.

**Special Food Product** means a food product that is: a. Prescribed by a Physician or nurse practitioner for the treatment of an inherited metabolic disease and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of such condition. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and b. Used in place of normal food products, such as grocery store foods used by the general population.

**SECTION VI - EXCLUSIONS AND LIMITATIONS**

**Exclusion Disclaimer:** Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

This Policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of this Policy and as shown in the Schedule of Benefits.

- **International Students Only** - Eligible expenses within the Insured Person’s Home Country or country of origin that would be payable or medical treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
- routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
• dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person’s Sound, Natural Teeth; or as stated in the Pediatric Dental Treatment Benefit.
• professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
• services or supplies not necessary for the medical care of the Insured Person’s Injury or Sickness.
• services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury; except as required by the Pediatric Vision Benefit.
• weak, strained or flat feet, corns, calluses or ingrown toenails.
• diagnostic or surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
• treatment or removal of nonmalignant moles, warts, boils, acne, actinic or seborrheic keratosis, dermatofibrosis or nevus of any description or form, hallus valgus repair, varicosity, or sleep disorders including the testing for same.
• expenses covered under any Workers’ Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
• 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.
• any expenses in excess of Usual and Reasonable charges.
• 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.
• 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.
• loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
• 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.
• services that are duplicated when provided by both a certified nurse-midwife and a Physician.
• expenses payable under any prior Policy which was in force for the person making the claim.
• Injury sustained as the result of the Insured Person’s operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
• expenses incurred after:
  o The date insurance terminates as to the Insured Person
  o The end of the Benefit Period specified in the Benefit Schedule.
• Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
• expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the policy.
• expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as required for repair caused by a Covered Injury; or the Pediatric Vision Benefit.
• racing or speed contests, skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV’s (all terrain or similar type vehicles) or other hazardous sport or hobby.
• expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
  o 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.
  o 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).
• an Insured Person’s:
  o committing or attempting to commit a felony,
  o being engaged in an illegal occupation, or
  o participation in a riot.
• custodial care service and supplies.

Third Party Refund - When:
1. an Insured Person is injured through the negligent act or omission of another person (the "third party"); and
2. benefits are paid under the Policy as a result of that Injury,

We are entitled to a refund by the Insured Person of all Policy benefits paid as a result of the Injury.

The refund must be made to the extent that the Insured Person receives payment for the Injury from the third party or that third party's insurance carrier. We may file a lien against that third-party payment. Reasonable pro rata charges, such as legal fees and court costs, may be deducted from the refund made to Us. The Insured Person must complete and return the required forms to Us upon request.

COORDINATION OF THIS POLICY’S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable expense.

DEFINITIONS

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.

(1) Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each Policy for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the Policy providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Policy providing health care benefits is separate from this plan. A Policy may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

4. If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

5. The amount of any benefit reduction by the Primary plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that has contracted with or is employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

**ORDER OF BENEFIT DETERMINATION RULES**

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.
B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policy holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
   i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
   ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
   i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
   ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
   iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
   iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
      • The Plan covering the Custodial parent;
      • The Plan covering the spouse of the Custodial parent;
      • The Plan covering the non-custodial parent; and then
      • The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If an Insured Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Our Agent or We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Our Agent or We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Our Agent or We any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.
RIGHT OF RECOVERY

If the amount of the payments made by Our Agent or We is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

SECTION VII - GENERAL POLICY PROVISIONS

Entire Contract. Changes: This Policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon. No agent has authority to change this Policy or waive any of its provisions.

Notice of Claim: Written notice of a claim must be given to Us within 90 days after the date of Injury or commencement of Sickness covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Our authorized agent, with information sufficient to identify the Insured Person will be deemed notice to Us.

Claim Forms: We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss provision.

Proof of Loss: Written proof of Loss must be furnished to Us or to our authorized agent within 90 days after the date of such Loss. If it was not reasonably possible to give written proof in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonable possible. The proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

Time of Payment: Indemnities payable under this Policy will be paid immediately upon receipt of due proof of such Loss.

Payment of Claims: Benefits will be paid to the Insured Person. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to the estate of an Insured Person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any one relative by blood or connection by marriage of the Insured Person who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless the Insured Person directs otherwise, in writing, by the time proofs of loss are filed. We cannot require that the services be rendered by a particular provider.

Physical Examination and Autopsy: We, at Our own expense, will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of death of an Insured Person, We may have an autopsy performed unless prohibited by law.
**Legal Actions:** No action at law or in equity will be brought to recover on this Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

**Conformity with State Statutes:** Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

**SECTION VIII - ADDITIONAL PROVISIONS**

1. We do not assume any responsibility for the validity of assignment.

2. The Insured Person will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.

3. Our acknowledgment of the receipt of notice given under this Policy, or the furnishing of forms for filing proofs of loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Policy.

4. This Policy is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium or comply with any of the provisions of this Policy when such failure is due to inadvertent error or clerical mistake.

7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Policy term and within one year after the termination of this Policy.

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

**SECTION IX – APPEALS PROCEDURE**

For purposes of this Section, the following definitions apply:

**Adverse Determination** means a determination by Us or Our designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a Covered Medical Expense has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated. Denials of coverage based on a determination that a service recommended or requested health care or treatment is experimental also are Adverse Determination and must comply with procedures for reviewing coverage denials based on a determination that a recommended or requested health care service or treatment is experimental.

**Prospective Review** means utilization review conducted prior to an admission or course of treatment.
**Retrospective Review** means a review of Medical necessity conducted after services have been provided to an Insured Person but does not include the review of the claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

**Internal Review Procedure**

1. In the event of an Adverse Determination, We will notify the Insured Person immediately in writing of Our decision and the reason for the Adverse Determination. The notice will include a description of any additional information that might be necessary for reconsideration of the claim and the notice will also describe the right to appeal. The Insured Person also had the right to contact the Commissioner of Insurance or his or her office at any time. *Pennsylvania Insurance Department, 1209 Strawberry Square, Harrisburg, PA 17120; 1-877-881-6388; www.insurance.pa.gov/*

2. A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. The Insured Person does not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative may:
   a. review all documents related to the claim and submit written comments and issues related to the denial;
   and
   b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

We will provide the Insured Person with the contact person who is coordinating the first level review within 3 days of the date of receipt of the grievance.

After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 30 days for a Prospective Review request or 60 days for a Retrospective Review request after receipt of the notice requesting the first level review.

We shall provide free of charge to the Insured Person, or the Insured Person’s authorized representative, any new or additional evidence, relied upon or generated by Us, or at Our direction, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the Insured Person, or the Insured Person’s authorized representative, a reasonable opportunity to respond prior to the date.

Before the We issue or provide notice of a final Adverse Determination that is based on new or additional rationale, We shall provide the new or additional rationale to the Insured Person, or the Insured Person’s authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final Adverse Determination is to be provided to permit the Insured Person, or the Insured Person ’s authorized representative a reasonable opportunity to respond prior to the date.

In the case of an Adverse Determination involving utilization review, We will designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to determine Adverse Determination. The clinical peer(s) shall not have been involved in the initial adverse determination. We shall ensure that the individuals reviewing the Adverse Determination have appropriate expertise.
Expedited reviews of grievances involving an Adverse Determination

We shall provide expedited review of a grievance involving an Adverse Determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility. The Insured Person or the Insured Person’s authorized representative shall request an expedited review orally or in writing. We will appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the Adverse Determination. The clinical peer or peers shall not have been involved in making the initial Adverse Determination. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the Insured Person or, if applicable, the Insured Person's authorized representative and Us by telephone, facsimile or the most expeditious method available. An expedited review decision shall be made and the Insured Person or, if applicable, the Insured Person's authorized representative shall be notified of the decision within seventy two (72) hours after the receipt of the request for the expedited review. If the expedited review is of a grievance involving an Adverse Determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the Insured Person until the Insured Person has been notified of the determination.

If the Insured Person Disagrees with Our Internal Review Determination

In the event that the Insured Person disagrees with Our internal review determination, the Insured Person or his or her authorized representative may:

a. File a complaint with the Pennsylvania Insurance Department, 1209 Strawberry Square, Harrisburg, PA 17120; 1-877-881-6388; www.insurance.pa.gov; or

b. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

The Insured Person also has the right to bring a civil action in a court of competent jurisdiction. Note that he or she may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the state Insurance Commissioner.

External Review Procedure

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

We shall notify the Insured Person in writing of the Insured Person's right to request an external review at the time the We send written notice of:

a. An Adverse Determination upon completion of the Our utilization review process described above; or

b. A final Adverse Determination.

An external review may be requested within 60 days after the Insured Person receives Our adverse benefit determination. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.

2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person.

3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.
4. We will review the request and if it is:
   a. Complete we will initiate the external review and notify the Insured Person of:
      i. The name and contact information for the assigned independent review organization or the Commissioner of Insurance, as applicable for the purpose of submitting additional information; and
      ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn’t apply to expedited request or external reviews that involve an experimental or investigational treatment.
   b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.

5. We will not afford the Insured Person an external review if:
   a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   b. The Insured Person has failed to exhaust Our internal review process; or
   c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

If We deny a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, We will notify the Insured Person in writing:
   a. The reason for the denial; and
   b. That the denial may be appealed to the Commissioner of Insurance.

6. For an expedited review: the Insured Person may make a request for an expedited external review after receiving an adverse benefit determination if:
   a. The Insured’s treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time frame of an expedited internal review.
   b. The Insured Person’s treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person, or would jeopardize the Insured Person’s ability to regain maximum function, if treated after the time frame of a standard external review.
   c. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.

7. An Insured Person shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by Us, the insurer.

8. At the request of the independent review organization, the Insured Person, provider, health care facility rendering health care services to the Insured Person, or Us shall provide any additional information the independent review organization requests to complete the review.

9. If the independent review organization does not receive any requested information necessary to complete the review they are not required to make a decision. They shall notify the Insured Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means.

10. We may elect to cover the service requested and terminate the review. We shall notify the Insured Person and all other parties involved with the decision by mail, or with the consent or approval of the Insured Person, by electronic means.

11. In the case of an expedited review, the independent review organization shall issue a written decision within seventy-two (72) hours after being assigned an expedited external review. In all other cases, written decision shall be issued no later than thirty (30) days after the filing of the request for review to the Insured Person, the insurer and the Insured Person’s provider or the health care facility if they requested the review. The written decision shall include a description of the Insured Person’s condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

12. We shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the Insured Person’s policy or certificate.
External Review of Denial of Experimental or Investigative Treatment

Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or the Insured Person's authorized representative may file a request for external review with the Commissioner of Insurance.

An Insured Person or the Insured Person's authorized representative may make an oral request for an external review of the Adverse Determination or final Adverse Determination if the Insured Person's treating Physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

Upon receipt of a request for an expedited external review, the Commissioner of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Commissioner of Insurance immediately shall notify and send a copy of the request to Us. For an expedited external review request, at the time We receive the notice, We or Our designee utilization review organization shall provide or transmit all necessary documents and information considered in making the Adverse Determination or final Adverse Determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.
It is understood and agreed that the Policy to which this Endorsement is attached is amended as follows:

The following benefits will be included in the Schedule of Benefits:

<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Centers or Facilities</td>
<td>The PPO Allowance stated above Deductible Waived if Student Health Center Referred Deductible Waived</td>
<td>The Usual and Reasonable Charge stated above Deductible Waived if Student Health Center Referred</td>
</tr>
<tr>
<td>Other Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Emergency Treatment outside the United States</td>
<td>The Non-Network Coinsurance Amount shown above</td>
<td></td>
</tr>
</tbody>
</table>

The following is added to the Description of Benefits section, under Outpatient Benefits:

**Urgent Care Centers or Facilities** for services provided at an Urgent Care Center or Facility, as shown in the Schedule of Benefits. We will not pay for more than one visit per day.

The following is added to the Description of Benefits section, under Other Benefits:

**Non-Emergency Treatment outside the United States** for non-emergency treatment of Covered Medical Expenses received when the Insured Person is traveling outside the United States.

In every other way, the Policy remains as is.
AMENDMENT TO DEFINITIONS

This Amendment makes the revisions listed below to the Policy and Certificate to which it is attached.

The definition of Accident is deleted in its entirety and replaced with the following:
Accident means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

The definition of Covered Injury is deleted in its entirety and replaced with the following:
Covered Injury means a bodily injury that is caused by the Accident directly and independently of all other causes. Coverage under the School’s policies must be in force on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

This Amendment is subject to all terms, conditions and provisions of the Policy/Certificate that are not inconsistent with it. Except as stated in this Amendment, it does not change or affect any other terms of the Policy and Certificate.

This Amendment takes effect on the same date as the Policy.


Kimberly A. Shaul
Secretary

Mark L. Solverud
President
Residents of Pennsylvania who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Pennsylvania Life and Health Insurance Guaranty Association (PLHIGA). The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in Pennsylvania and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Association is limited, however. As noted below, this protection is not a substitute for consumers’ care in selecting companies that are well managed and financially stable. Insurance companies and their agents are prohibited by law from using the existence of the association to induce you to purchase any kind of insurance policy.

This Information is Provided By:

Pennsylvania Life and Health Insurance Guaranty Association
290 King of Prussia Road
Radnor Station Building 2, Suite 218
Radnor, PA  19087
(610) 975-0572

SUMMARY

The state law that provides for this safety-net coverage is called the Pennsylvania Life and Health Insurance Guaranty Association Act. Below is a brief summary of the law’s coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone’s rights or obligations under the act or the rights or obligations of the Association.

Coverage. Generally, individuals will be protected by the Pennsylvania Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they hold certificates under a group life or health insurance contract or annuity, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

Exclusion From Coverage. Persons holding such policies or contracts are not protected by this Association if:

- they are not residents of the State of Pennsylvania, except under certain very specific circumstances;
- the insurer was not authorized or licensed to do business in Pennsylvania at the time the policy or contract was issued;
- their policy was insured by a nonprofit hospital or health service corporation (e.g., a blue cross or blue shield plan), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

(please turn to back of page)
The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk;
- any policy of reinsurance (unless an assumption certificate was issued);
- plans of employers, association or similar entities to the extent they are self-funded or uninsured (that is, not insured by an insurance company, even if an insurance company administers them);
- interest rate yields that exceed an average rate;
- dividends;
- experience rating credits;
- credits given in connection with the administration of a policy or contract;
- annuity contracts or group annuity certificates used by nonprofit insurance companies to provide retirement benefits for nonprofit educational institutions and their employees;
- policies, contracts, certificates or subscriber agreements issued by a prepaid dental care plan;
- sickness and accident insurance when written by a property and casualty insurer as part of an automobile insurance contract;
- unallocated annuity contracts issued to an employee benefit plan protected under the federal Pension Benefit Guaranty Corporation;
- financial guarantees, funding agreements or guaranteed investment contracts not containing mortality guarantees and not issued to or in connection with a specific employee benefit plan or government lottery;
- any kind of insurance or annuity, the benefits of which are exclusively payable or determined by a separate account required by the terms of such insurance policy or annuity maintained by the insurer or by a separate entity.

**Limits On Amount of Coverage.** The act also limits the amount of the Association is obligated to pay out. The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages.

Subject to the overall $300,000 limit, the Association will pay up to $300,000 in life insurance death benefits, but not more than $100,000 in net cash surrender or withdrawal values. For annuities, the Association will pay up to $300,000 in annuity benefits, or $100,000 in net cash surrender or withdrawal benefits. For health insurance the Association will pay up to $100,000, including any net cash surrender or withdrawal benefits.
NGL Insurance Group Privacy Notice
National Guardian Life Insurance Company
Settlers Life Insurance Company

The listed companies of the NGL Insurance Group (or “NGL”) are committed to protecting the privacy of the personal information we receive (“Information”) about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is “your privacy is our priority.”

Why We Collect and How We Use Information:
When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other NGL products or services.

Types of Information We Collect:
We collect most Information directly from you on applications or from other communications with you during the application process. Types of Information we could collect include, but are not limited to:
- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

We also may keep Information about your transactions with us:
- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:
- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:
Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:
- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

NGL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other NGL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, NGL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:
You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

Massachusetts Policyholders: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

How We Protect Your Information:
NGL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on NGL’s website, www.nglic.com.
JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commercial Travelers Mutual Insurance Company and National Guardian Life Insurance Company are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How We May Use or Disclose Your Health Information

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. **Required by Law.** As required by law, we may use and disclose your health information. We may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. **Public Health.** As required by law, we may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Health and Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. **Government Functions.** We may disclose your health information for military, national security, prisoner and government benefits purposes.

9. **Worker’s Compensation.** We may disclose your health information as necessary to comply with worker’s compensation or similar laws.

10. **Disclosures to Plan Sponsors.** We may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request.
2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, we may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that we amend your health information. We are not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. We will provide one list per 12 month period free of charge; we may charge you for any additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

**Our Obligations Under This Notice**

**We are required by law to:**

1. Maintain the privacy of your health information.

2. Provide you with a notice of our legal duties and privacy practices with respect to your health information.

3. Abide by the terms of this Notice.


5. Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.

6. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

7. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law, including psychotherapy notes, personal health information for marketing purposes, and information in instances constituting the sale of personal health information.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that we maintain. Revised Notices will be distributed to you by mail.

**Complaints**

If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer  
Commercial Travelers Mutual Insurance Company  
70 Genesee Street  
Utica, NY 13502

You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

**Effective Date of This Notice: September 23, 2013.**
APPLICATION FOR STUDENT BLANKET ACCIDENT AND SICKNESS INSURANCE

1. Name of School, College or University: Bucknell University

Address: 701 Moore Ave., Lewisburg, PA 17837

2. Plan of Benefits:

☐ Same as current year’s program, except

☐ In accordance with proposal dated , 20

☒ Other In accordance with attached Policy No.2016I5B05 and all attachments thereto.

3. Premium Rates:

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Fall</th>
<th>Spring/Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student:</td>
<td>$1,997.00</td>
<td>$837.00</td>
<td>$1,061.00</td>
</tr>
<tr>
<td>Spouse:</td>
<td>$1,997.00</td>
<td>$837.00</td>
<td>$1,061.00</td>
</tr>
<tr>
<td>Child(ren):</td>
<td>$1,997.00</td>
<td>$837.00</td>
<td>$1,061.00</td>
</tr>
</tbody>
</table>

4. Terms of coverage, from: August 1, 2016 To: July 31, 2017

Any Policy issued by National Guardian Life Insurance Company in consideration of this Application and payment of the first premium will include only those benefits shown in the proposal and agreed to by Us and the Applicant.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

__________________________________________  ____________________________________________  ____________
Signature of School Official                  Position or Title                         Date

Agent/Broker Name: ________________________________________________________________

Address: ________________________________________________________________________

_______________________________________________________________________________

Tax I.D./Social Security Number ____________________________________________________

NBH-280 (APP)-PA