Student Health Insurance Plan

Plan Year
17/18

Designed Exclusively for the Students of:
Kent State University
College of Podiatric Medicine
Independence, OH
2017 - 2018

Underwritten by:
National Guardian Life Insurance Company
Madison, WI

Policy Number: 2017I5C06
Group Number: ST0862SH
Effective: 8/1/2017 - 8/1/2018

Administered by:
Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA
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Where to Find Help

<table>
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<tr>
<th>For Questions About:</th>
<th>Please Contact:</th>
</tr>
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<tbody>
<tr>
<td>Insurance Benefits</td>
<td>Kent State University College of Podiatric Medicine</td>
</tr>
<tr>
<td>Enrollment</td>
<td>6000 Rockside Woods Boulevard</td>
</tr>
<tr>
<td>Waiver</td>
<td>Independence, OH 44131</td>
</tr>
<tr>
<td></td>
<td>Phone: 216-916-7489</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>Consolidated Health Plans</td>
</tr>
<tr>
<td>ID Cards</td>
<td>2077 Roosevelt Avenue</td>
</tr>
<tr>
<td>Preferred Provider Listings</td>
<td>Springfield, Massachusetts 01104</td>
</tr>
<tr>
<td>ID card Requests</td>
<td>(877) 657-5030</td>
</tr>
<tr>
<td></td>
<td><a href="http://www.chpstudent.com">www.chpstudent.com</a></td>
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<tr>
<td>Preferred PPO Provider Listings</td>
<td>Consolidated Health Plans</td>
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<td><a href="http://www.cigna.com">www.cigna.com</a></td>
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<tr>
<td>Prescription Drug Providers</td>
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<td><a href="http://www.cigna.com">www.cigna.com</a></td>
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Am I Eligible?

To be eligible for this Insurance Program, You must be enrolled in one (1) or more credit hours. If You are eligible to be covered under this Program, You are automatically enrolled unless You can certify that You have comparable coverage.

Online (Distance Learning) students taking more than 1/3 of their total credit hours per term, Home study, correspondence, Internet, and television (TV) courses do not fulfill the Eligibility requirements.

You are eligible for Coverage if You meet the definition of Eligible Person as determined by the Policyholder and Us. Eligible individuals voluntarily withdrawing from school during the first thirty-one (31) days of the period for which Coverage is purchased, will not be covered under the Policy and a full refund of Premium will be made. Individuals withdrawing after such thirty-one (31) days will remain covered under the Policy for the term purchased and no refund will be allowed except as otherwise specified herein.

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

Eligibility requirements must be met each time Premium is paid to renew Coverage.

This brochure provides a general summary of the insurance coverage. Keep this brochure as no individual policy will be issued. This summary is not a contract; however, the Master Policy will be available for review upon request. The Master Policy contains the contract provisions and shall prevail in the event of any conflict between this brochure and the Master Policy.
Coverage for Dependents

Eligible individuals may also insure, on a Voluntary Participation Basis, their eligible Dependents. Individuals who enroll their dependents must enroll them within (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). They 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).

How Do I Waive/Enroll?

Eligible Students who DO NOT WANT to be enrolled in the Student Health Insurance Program must submit an online Waiver Form documenting proof of comparable coverage in another health insurance plan prior to the posted waiver date.

Recognizing that health insurance situations may change, students will be required to provide proof of comparable coverage each academic year in order to waive participation in the Student Health Insurance Program.

Please note: The Company issuing the policy, used to waive inclusion in the Student Health Insurance Program, must be wholly based in the United States.

All students enrolled in one (1) or more credit hours are eligible and are automatically enrolled in this insurance plan unless proof of comparable insurance coverage is provided by the waiver deadlines.

To waive the KSUPM Student Health Insurance Plan go to:

1. www.chpstudent.com;
2. Select Kent State University College of Podiatric Medicine from the dropdown box;
3. Next click on the “Waiver” tab; and
4. Proceed as directed.

The deadline to waive is as follows:

   Annual Term – September 5, 2017

If an online waiver is not submitted by the waiver deadline You will automatically be enrolled in the KSUPM Student Health Insurance Plan and the insurance fee will remain on your tuition bill.

Students who successfully waive coverage from the school-sponsored Plan but lose that coverage any time after the Waiver Deadline Date, may enroll in the Student Health Insurance Plan at a pro-rated insurance rate. Applications must be received with 31 days of the Qualifying Life Event (date of the loss of other coverage). Your effective date of coverage under this Insurance Program will be the date that Your former insurance expired, but only if You make the request for coverage within thirty-one (31) days from the date that Your previous plan expired. Otherwise, the Effective Date of coverage will be the first (1st) of the month following Our receipt of Your written request for coverage. The appropriate premium must accompany Your application for coverage.

•   ANNUAL WAIVER DEADLINE – September 5, 2017

Qualifying Life Event

No changes of any type may be made during the plan year unless a qualified family or employment status change occurs. In all cases, the change in coverage must be consistent with the change in the person’s family or employment status. If you do have a qualifying change in status, you have 31 days from the event to make changes to your elections by completing a Qualifying Event Notification form and paying any applicable premium.
Effective Dates & Costs

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Coverage Start Date</th>
<th>Coverage End Date</th>
<th>Enrollment/Waiver Deadline</th>
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<tbody>
<tr>
<td>Annual</td>
<td>08/01/2017</td>
<td>08/01/2018</td>
<td>09/05/2017</td>
</tr>
<tr>
<td>Fall</td>
<td>08/01/2017</td>
<td>01/01/2018</td>
<td>09/05/2017</td>
</tr>
<tr>
<td>Spring</td>
<td>01/01/2018</td>
<td>08/01/2018</td>
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</tbody>
</table>

Rates for International, Graduate and Undergraduate students.
Dependent rates are in addition to the student rate.

<table>
<thead>
<tr>
<th></th>
<th>Annual</th>
<th>Fall</th>
<th>Spring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student*</td>
<td>$3,100</td>
<td>$1,300</td>
<td>$1,800</td>
</tr>
<tr>
<td>Spouse*</td>
<td>$3,100</td>
<td>$1,300</td>
<td>$1,800</td>
</tr>
<tr>
<td>Each Child*</td>
<td>$3,100</td>
<td>$1,300</td>
<td>$1,800</td>
</tr>
<tr>
<td>3 or more Children*</td>
<td>$9,300</td>
<td>$3,900</td>
<td>$5,400</td>
</tr>
</tbody>
</table>

*The above rates include an administrative service fee

Insurance under the 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.

The Policy is issued as a new policy for the term August 1, 2017 to August 1, 2018 as Policy Number 2017I5C06. All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.

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 of Benefits

An Insured Person’s insurance will terminate on the earliest of:
1. On any premium due date the Policyholder fails to pay the required premium in accordance with the terms of the Policy except as the result of an inadvertent error;
2. The date this insurance product is discontinued in accordance with the state laws of the state of Ohio;
3. The date fraud or intentional misrepresentation of fact in connection with the Policy is committed by the Insured Person; or
4. The date the Policyholder requests termination of the Policy. We will not terminate the coverage of an Insured Person based solely on any health status related factor of that person.

**Premium Refund Policy**

**Refund of Premium:** Premiums received by the Company 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 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.

No other refunds will be allowed.

**Definitions**

If a word or phrase in this document have special meaning, or is a title, it will start with a capital letter. If the word or phrase is not explained in the text where it appears, it will be defined in this section. If an Insured Person needs additional clarification on any of these definitions, please contact the customer service number located on the back of an Insured Person’s ID Card or submit an Insured Person’s question online at [www.studentplanscenter.com](http://www.studentplanscenter.com).

**Benefit Period** – The length of time that We will pay benefits for Covered Services. The Benefit Period is listed in the Schedule of Benefits. If an Insured Person’s coverage ends before this length of time, then the Benefit Period also ends.

**Brand Name Drug** – The first version of a particular medication to be developed or a medication that is sold under a pharmaceutical manufacturer’s own registered trade name or trademark. The original manufacturer is granted a patent, which allows it to be the only company to make and sell the new drug for a certain number of years.

**Certificate** – The document providing a summary of the terms of an Insured Person’s benefits. It is attached to, and is a part of, the Policy. It is also subject to the terms of the Policy.

**Copayment** – A specific dollar amount of the Maximum Allowable Amount for Covered Services, indicated in the Schedule of Benefits, which An Insured Person must pay. The Copayment does not apply to any Deductible that an Insured Person is required to pay. An Insured Person’s Copayment will be the lesser of the amount shown in the Schedule of Benefits or the amount charged by the Provider.

**Coinsurance** - A specific percentage of the Maximum Allowable Amount for Covered Services, that is indicated in the Schedule of Benefits, which An Insured Person must pay. Coinsurance normally applies after the Deductible that an Insured Person is required to pay. See the Schedule of Benefits for any exceptions.

**Compound Drugs** - A drug, which requires a prescription from a Physician, that is prepared by a pharmacist who mixes or adjusts drug ingredients to customize a medication to meet an Insured Person’s individual needs.

**Covered Services** - Services, supplies or treatment as described in this Certificate which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service the service, supply or treatment must be:

- Medically Necessary or otherwise specifically included as a benefit under this Certificate.
- Within the scope of the license of the Provider performing the service.
- Rendered while coverage under this Certificate is in force.
- Not Experimental/Investigative or otherwise excluded or limited by this Certificate, or by any amendment or rider thereto.

A charge for a Covered Service is incurred on the date the service, supply or treatment was provided to an Insured Person. The incurred date (for determining application of Deductible and other Insured Person Cost Share amounts) for an Inpatient admission is the date of admission except as otherwise specified in benefits after termination. Covered Services do not include any services or supplies that are not documented in Provider records.

Covered Services includes treatment for Mental Health Disorders and Substance Use Disorders.

**Covered Transplant Procedure** - Any Medically Necessary human organ and tissue transplant as determined by Us including necessary acquisition costs and preparatory myeloblative therapy.

**Covered Transplant Services** - All Covered Transplant Procedures and all Covered Services directly related to the disease that has necessitated the Covered Transplant Procedure or that arises as a result of the Covered Transplant Procedure, including any Diagnostic evaluation for the purpose of determining an Insured Person’s appropriateness for a Covered Transplant Procedure.
Custodial Service or Care - Care primarily for the purpose of assisting an Insured Person in the activities of daily living or in meeting personal rather than medical needs. Custodial Care is not specific treatment for an illness or injury. Care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:

- Assistance with walking, bathing, or dressing
- Transfer or positioning in bed
- Normally self-administered medicine
- Meal preparation
- Feeding by utensil, tube, or gastrostomy
- Oral hygiene
- Ordinary skin and nail care
- Catheter care
- Suctioning
- Using the toilet
- Enemas
- Preparation of special diets and supervision over medical equipment or exercises or over self-administration of oral medications not requiring constant attention of trained medical personnel.

Care can be Custodial regardless of whether it is recommended by a professional or performed in a facility, such as a Hospital or Skilled Nursing Facility, or at home.

Deductible – The dollar amount of Covered Services, listed in the Schedule of Benefits, which an Insured Person must pay for before We will pay for those Covered Services in each Benefit Period.

Dependent – Includes

1. an Insured Student’s lawful spouse;
2. the following dependent children of an Insured Student who are under age 26:
   - biological child;
   - adopted child;
   - stepchild;
   - child for whom the Insured Student is required by a court order to provide coverage.
   The Insured Student can choose to continue coverage for an unmarried child to the age of 28 if all of the following are true:
   - The child is the natural child, stepchild, or adopted child of the insured.
   - The child is a resident of this state or a full-time student at an accredited public or private institution of higher education.
   - The child is not employed by an employer that offers any Health Benefit Plan under which the child is eligible for coverage.
   - The child is not eligible for coverage under the Medicaid program established under Chapter 5111. of the Revised Code or the Medicare program established under Title XVIII of the “Social Security Act,” 42 U.S.C. 1395.
3. An Insured Student’s unmarried biological or adopted child, stepchild, or court ordered covered child who has reached age 26 (or 28 if covered) and:
   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.

The Schedule of Benefits indicates whether this plan includes Dependent coverage.

Diagnostic (Service/Testing) – A test or procedure performed on an Insured Person, who is displaying specific symptoms, to detect or monitor a disease or condition. A Diagnostic Service also includes a Medically Necessary Preventive Care screening test that may be required for an Insured Person who is not displaying any symptoms. However, this must be ordered by a Provider. Examples of covered Diagnostic Services in the Covered Services section.

Domiciliary Care – Care provided in a residential institution, treatment center, halfway house, or school because an Insured Person’s own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
Effective Date – The date that an Insured Student’s coverage begins under this Certificate. A Dependent’s coverage also begins on the Insured Student’s Effective Date. The Schedule of Benefits indicates whether this Plan includes coverage for Dependents.

Eligible Person – A person who meets the School’s requirements and is entitled to apply to be an Insured Student.

Emergency (Emergency Medical Condition) – An accidental traumatic bodily injury or other medical condition that manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to:

• Place the health of an individual, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
• Result in serious impairment to the individual’s bodily functions; or
• Result in serious dysfunction of a bodily organ or part of the individual.

Emergency Care (Emergency Services) - A medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate an Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to Stabilize the patient.

Experimental/Investigative – Any Drug, biologic, device, Diagnostic, product, equipment, procedure, treatment, service, or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which We determine to be unproven. For how this is determined, see the “Non-Covered Services/Exclusions” section.

Family Coverage – Coverage for the Insured Student and all eligible Dependents. The Schedule of Benefits indicates whether this Plan includes Family Coverage.

Formulary - The list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness.

Generic Drugs – Prescription Drugs that have been determined by the FDA to be equivalent to Brand Name Drugs, but are not made or sold under a registered trade name or trademark. Generic Drugs have the same active ingredients, meet the same FDA requirements for safety, purity, and potency and must be dispensed in the same dosage form (tablet, capsule, cream) as the Brand Name Drug.

Group – The School, or other organization, that has entered into a Policy with the Plan.

Habilitative Services – Health care services and devices that help an Insured Person keep, learn, or improve skills and functioning for daily living.

Identification Card / ID Card – A card issued by the Plan, showing the Insured Person’s name, membership number, and occasionally coverage information.

Inpatient – An Insured Person who receives care as a registered bed patient in a Hospital or other Provider where a room and board charge is made. This does not apply to an Insured Person who is placed under observation for fewer than 24 hours.

Insured Person - An Insured Student or Dependent who has satisfied the eligibility conditions, applied for coverage, been approved by the plan, and been covered by the required Premium payment.

Insured Student – A student of the School who is eligible to receive benefits under the Policy. You or Your also means the Insured Student.

Maximum Allowable Amount (Maximum Allowed Amount) - The maximum amount that We will allow for Covered Services received. The Maximum Allowable Amount is:

• Not in excess of the PPO Allowance. We will pay up to the PPO Allowance.
• Not in excess of the Usual and Reasonable charge. We will pay up to the Usual and Reasonable charge.
• Not in excess of the charges that would have been made in the absence of this insurance. We will pay up to the charges that would have been made in the absence of this insurance.

The Maximum Allowable Amount determination is described in the Schedule of Benefits.

Medically Necessary/ Medical Necessity - An intervention that is or will be provided for the diagnosis, evaluation and treatment of a condition, illness, disease or injury and that is determined by Us to be:

• Medically appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Insured Person’s condition, illness, disease or injury;
• Obtained from a Provider;
• Provided in accordance with applicable medical and/or professional standards;
• Known to be effective, as proven by scientific evidence, in materially improving health outcomes;
• The most appropriate supply, setting or level of service that can safely be provided to the Insured Person and
which cannot be omitted consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting);

- Cost effective compared to alternative interventions, including no intervention ("cost effective" does not mean lowest cost);
- Not Experimental/Investigative;
- Not primarily for the convenience of the Insured Person, the Insured Person’s family or the Provider.
- Not otherwise subject to an exclusion under this Certificate.

The fact that a Provider may prescribe, order, recommend, or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically Necessary or a Covered Service and does not guarantee payment.

**Medicare** - The program of health care for the aged and disabled established by Title XVIII of the Social Security Act, as amended.

**Mental Health Disorder** – 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.

**New FDA Approved Drug Product or Technology** - The first release of the brand name product or technology upon the initial FDA New Drug Approval. Other applicable FDA approval for its biochemical composition and initial availability in the marketplace for the indicated treatment and use. New FDA Approved Drug Product or Technology does not include:

- New formulations: a new dosage form or new formulation of an active ingredient already on the market;
- Already marketed Drug product but new manufacturer: a product that duplicates another firm’s already marketed Drug product (same active ingredient, formulation, or combination);
- Already marketed Drug product, but new use: a new use for a Drug product already marketed by the same or a different firm; or
- Newly introduced generic medication: generic medications contain the same active ingredient as their counterpart brand-named medications.

**Network Providers** - Providers, Hospitals, or other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

**Non-Network Providers** – Providers who have not agreed to any pre-arranged fee schedules.

**Out of Pocket Expense Limit** - A specified dollar amount of expense incurred by an Insured Person and/or family for Covered Services in a Benefit Period as listed on the Schedule of Benefits. When the Out of Pocket Expense Limit is reached for an Insured Person and/or family, then no additional Deductibles, Coinsurance, and Copayments are required for that person and/or family unless otherwise specified in this Certificate and/or the Schedule of Benefits. 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 for all Essential Health Benefits. The Out of Pocket Expense Limit does not apply to non-Essential Health Benefits, non-Covered services, or balance billed amounts for services received from a Non-Network Provider. The individual Out of Pocket Expense Limit applies to each individual Insured Person, regardless of whether the policy is for a single Insured Person or a Family. If an Insured Person meets the individual Out of Pocket Expense Limit, no Deductibles, Coinsurance, and Copayments are required for that person for any Essential Health Benefits for the remainder of the Policy Year and any benefits after the Out of Pocket Expense Limit has been met for that Insured Person will be covered at 100%. If the Family Out of Pocket Expense Limit is met, whether by one Insured Person or a combination of family members, benefits will be paid at 100% for all Insured Persons until the end of the Policy Year.

**Outpatient** - An Insured Person who receives services or supplies while not an Inpatient.

**Pharmacy and Therapeutics (P&T) Committee** – A committee consisting of health care professionals, including Nurses, Pharmacists, and Physicians. The purpose of this committee is to assist in determining clinical appropriateness of Drugs; determining the assignments of Drugs; determining whether a Drug will be included in any of the Formularies; and advising on programs to help improve care. Such programs may include, but are not limited to, drug utilization programs, therapeutic conversion programs, cross-branded initiatives, drug profiling initiatives and the like.

**Plan (or We, Us, Our)** – National Guardian Life Insurance Company which provides benefits to Insured Persons for the Covered Services described in this Certificate.

**PPO Allowance** – the amount a Network Provider will accept as payment in full for Covered Services.
Premium – The charges that must be paid by the Insured Student or the Group to maintain coverage. This may be based on an Insured Person’s age, depending on the School’s Contract with the Plan.

Prescription Order – A legal request, written by a Provider, for a Prescription Drug or medication and any subsequent refills.

Prescription Legend Drug, Prescription Drug, or Drug – A medicinal substance that is produced to treat illness or injury and is dispensed to Outpatients. Under the Federal Food, Drug & Cosmetic Act, such substances must bear a message on its original packing label that states, “Caution: Federal law prohibits dispensing without a prescription.” Compounded (combination) medications, which contain at least one such medicinal substance, are considered to be Prescription Legend Drugs. Insulin is considered a Prescription Legend Drug under this Certificate.

Provider – A duly licensed person or facility that provides services within the scope of an applicable license. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider. Providers include, but are not limited to, the following persons and facilities listed below. If an Insured Person has a question about a Provider not shown below, please call the number on the back of an Insured Person’s ID card.

- Alcoholism Treatment Facility - A facility that mainly provides detoxification and/or rehabilitation treatment for alcoholism.
- Alternative Care Facility – A non-Hospital health care facility, or an attached facility designated as free standing by a Hospital that the Plan approves, which provides Outpatient Services primarily for but not limited to:
  1. Diagnostic Services such as Computerized Axial Tomography (CAT scan) or Magnetic Resonance Imaging (MRI)
  2. Surgery
  3. Therapy Services or rehabilitation.

- Ambulatory Surgical Facility - A facility, with an organized staff of Physicians, that:
  1. Is licensed as such, where required;
  2. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis;
  3. Provides treatment by or under the supervision of Physicians and nursing services whenever the patient is in the facility;
  4. Does not provide Inpatient accommodations; and
  5. Is not, other than incidentally, used as an office or clinic for the private practice of a Physician or other professional Provider.

- Clinical Nurse Specialists whose nursing specialty is Mental Health
- Day Hospital - A facility that provides day rehabilitation services on an Outpatient basis.
- Dialysis Facility - A facility which mainly provides dialysis treatment, maintenance or training to patients as an Outpatient or at an Insured Person’s home. It is not a Hospital.
- Drug Abuse Treatment Facility - A facility which provides detoxification and/or rehabilitation treatment for drug abuse.
- Home Health Care Agency - A facility, licensed in the state in which it is located, which:
  1. Provides skilled nursing and other services on a visiting basis in the Insured Person’s home; and
  2. Is responsible for supervising the delivery of such services under a plan prescribed and approved in writing by the attending Physician.

- Home Infusion Facility - A facility which provides a combination of:
  1. Skilled nursing services
  2. Prescription Drugs
  3. Medical supplies and appliances
  Provided in the home as home infusion therapy for Total Parenteral Nutrition (TPN), Antibiotic therapy, Intravenous (IV) Chemotherapy, Enteral Nutrition Therapy, or IV pain management.

- Hospice - A coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care is available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

- Hospital - A Provider constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which:
  1. Provides room and board and nursing care for its patients;
  2. Has a staff with one or more Physicians available at all times;
3. Provides 24 hour nursing service;
4. Maintains on its premises all the facilities needed for the diagnosis, medical care, and treatment of an illness or injury; and
5. Is fully accredited by the Joint Commission on Accreditation of Health Care Organizations.

The term Hospital does not include a Provider, or that part of a Provider, used mainly for:
1. Nursing care
2. Rest care
3. Convalescent care
4. Care of the aged
5. Custodial Care
6. Educational care
7. Treatment of alcohol abuse
8. Treatment of drug abuse

- **Independent Social Workers**
- **Outpatient Psychiatric Facility** - A facility which mainly provides Diagnostic and therapeutic services for the treatment of Mental Health Disorders or Substance Use Disorders on an Outpatient basis.
- **Pharmacy** - An establishment licensed to dispense Prescription Drugs and other medications through a duly licensed pharmacist upon a Physician’s order.
- **Physician** - A legally licensed doctor of medicine, doctor of osteopathy (bones and muscles), Chiropractor (spinal column and other body structures), dental surgeon (teeth), podiatrist (diseases of the foot) or surgical chiropodist (surgical foot specialist) or optometrist (eye and sight specialist).
- **Professional Clinical Counselors** - A licensed or certified clinical mental health counselor.
- **Professional Counselors** - A licensed professional mental health counselor.
- **Psychiatric Hospital** - A facility that, for compensation of its patients, is primarily engaged in providing Diagnostic and therapeutic services for the Inpatient treatment of Mental Health Disorders or Substance Use Disorders. Such services are provided, by or under the supervision of, an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Psychologist** - A licensed clinical Psychologist. In states where there is no licensure law, the Psychologist must be certified by the appropriate professional body.
- **Rehabilitation Hospital** - A facility that is primarily engaged in providing rehabilitation services on an Inpatient or Outpatient basis. Rehabilitation care services consist of the combined use of medical, social, educational, and vocational services to enable patients disabled by disease or injury to achieve some reasonable level of functional ability. Services are provided by or under the supervision of an organized staff of Physicians. Continuous nursing services are provided under the supervision of a Registered Nurse.
- **Retail Health Clinic** - A facility that provides limited basic medical care services to Insured Persons on a “walk-in” basis. These clinics normally operate in major pharmacies or retail stores. Medical services are typically provided by Physicians Assistants and Nurse Practitioners.
- **Skilled Nursing Facility** - A Provider constituted, licensed, and operated as set forth in applicable state law, which:
  1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
  2. provides care supervised by a Physician;
  3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
  4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
  5. is not a rest, educational, or custodial Provider or similar place.
- **Social Worker** - A licensed Clinical Social Worker. In states where there is no licensure law, the Social Worker must be certified by the appropriate professional body.
- **Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Orthotic Devices**
- **Urgent Care Center** - A licensed health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, for Urgent Care.

**Recovery** – A Recovery is money an Insured Person receives from another, their insurer or from any “Uninsured Motorist”, “Underinsured Motorist”, “Medical-Payments”, “No-Fault”, or “Personal Injury Protection” or other
insurance coverage provision as a result of injury or illness caused by another. Regardless of how an Insured Person or an Insured Person’s representative or any agreements characterize the money an Insured Person receives, it shall be subject to the Subrogation and Reimbursement provisions of this Plan.

School or College - the college or university attended by the Insured Student. The School or College is the Policyholder.

Single Coverage – Coverage that is limited to the Insured Student only.

Stabilize - The provision of medical treatment to an Insured Person in an Emergency as may be necessary to assure, within reasonable medical probability, that material deterioration of an Insured Person’s condition is not likely to result from or during any of the following:

• an Insured Person’s discharge from an emergency department or other care setting where Emergency Care is provided to an Insured Person; or
• an Insured Person’s transfer from an emergency department or other care setting to another facility; or
• an Insured Person’s transfer from a Hospital emergency department or other Hospital care setting to the Hospital’s Inpatient setting.

Substance Use Disorder - 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.

Therapy Services – Services and supplies that are used to help a person recover from an illness or injury. Covered Therapy Services are limited to services listed in the "Covered Services" section.

Usual and Reasonable (U & R) - 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 a:

• Like service by a provider with similar training or experience; or
• Supply that is identical or substantially equivalent.

You, Your – Insured Student

Schedule of Benefits

SCHEDULE OF BENEFITS

Metal Level: Gold Actuarial Value: 79.22% Next Lower Metal Level: Silver

The Schedule of Benefits is a summary of the Deductibles, Coinsurance, Copayments, maximums and other limits that apply when you receive Covered Services from a Provider. Please refer to the "Covered Services" section of this Certificate for a more complete explanation of the specific services covered by the Plan. All Covered Services are subject to the conditions, exclusions, limitations, terms and provisions of this Certificate including any endorsements, amendments, or riders.

This Schedule of Benefits lists Your responsibility for Covered Services. To receive maximum benefits at the lowest Out-of-Pocket expense, Covered Services must be provided by a Network Provider. Benefits for Covered Services are based on the Maximum Allowable Amount, which is the maximum amount the Plan will pay for a given service. When you use a Non-Network Provider, you are responsible for any balance due between the Non-Network Provider’s charge and the Maximum Allowable Amount in addition to any Coinsurance, Copayments, Deductibles, and non-covered charges.

Under certain circumstances, if We pay the Provider amounts that are your responsibility, such as Deductibles, Copayments or Coinsurance, We may collect such amounts directly from you. You agree that We have the right to collect such amounts from you.

Essential Health Benefits provided within this Certificate are not subject to lifetime or annual dollar maximums. Certain non-essential health benefits, however, may be subject to either a lifetime and/or annual dollar maximum.

Essential Health Benefits are defined by federal law and refer to benefits in at least the following categories:

• Ambulatory patient services,
• Emergency services,
- Hospitalization,
- Maternity and newborn care,
- Mental health and substance use disorder services, including behavioral health treatment,
- Prescription drugs,
- Rehabilitative and habilitative services and devices,
- Laboratory services,
- Preventive and wellness services, and
- Chronic disease management and pediatric services, including oral and vision care

Such benefits shall be consistent with those set forth under the Patient Protection and Affordable Care Act of 2010 and any regulations issued pursuant thereto.

**Benefit Period** begins on August 1, 2017 and ends on August 1, 2018

**Dependent Coverage**

- Yes ☒
- No ☐

**Preventive Services**

Network Provider: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the PPO Allowance 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 Expense Limit.

**Deductible**

- Network $1,000
- Non-Network $2,000

**Out of Pocket Expense Limit**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Individual Limit</th>
<th>Family Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Provider</td>
<td>$6,000</td>
<td>$12,000</td>
</tr>
<tr>
<td>Non-Network Provider</td>
<td>$12,000</td>
<td>$24,000</td>
</tr>
</tbody>
</table>

The Out of Pocket Expense Limit will never exceed the amount shown above for an Insured Person, regardless of whether the Family Out of Pocket Expense Limit has been met. Benefits will be paid at 100% after the Out of Pocket Expense Limit has been met for an Insured Person. If the Family Out of Pocket Expense Limit is met, whether by one Insured Person or a combination of family members, benefits will be paid at 100% for all Insured Persons until the end of the Policy Year.

**Coinsurance:**

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Coinsurance Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Network Provider</td>
<td>20% of PPO Allowance for Covered Services unless otherwise stated below.</td>
</tr>
<tr>
<td>Non-Network Provider</td>
<td>40% of Usual and Reasonable Charge for Covered Services unless otherwise stated below.</td>
</tr>
</tbody>
</table>

**COVERED MEDICAL EXPENSES FOR AN ISSUED POLICY WILL BE:**

1. **THOSE LISTED IN THE COVERED SERVICES SECTION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICES OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**
<table>
<thead>
<tr>
<th>BENEFITS FOR COVERED SERVICES</th>
<th>LIMITS AND INSURED’S RESPONSIBILITY NETWORK PROVIDERS</th>
<th>LIMITS AND INSURED’S RESPONSIBILITY NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>20% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Autism Spectrum Disorder for children up to age 21: Speech Therapy – 20 visits per policy year Language Therapy – 20 visits per policy year Occupational Therapy – 20 visits per policy year Clinical Therapeutic Intervention – 20 visits per policy year Mental/Behavioral Health Outpatient Services – 20 visits per policy year</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Mental Health Disorder Services Coverage for the Inpatient and Outpatient treatment including Physician Home Visits and Offices Services</td>
<td>Same as any other Covered Service</td>
<td>Same as any other Covered Service</td>
</tr>
<tr>
<td>Substance Use Disorder Services Coverage for the Inpatient and Outpatient treatment including Physician Home Visits and Offices Services</td>
<td>Same as any other Covered Service</td>
<td>Same as any other Covered Service</td>
</tr>
<tr>
<td>Approved Clinical Trials</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Dental Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Services related to an accidental Injury</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>20% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Other Dental Services – facility charges and anesthesia only</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Pediatric Dental Services</td>
<td>The Preventive Services Coinsurance Amount except that orthodontia will be paid at 50% Coinsurance</td>
<td>50% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Diabetes Equipment, Education and Supplies</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>The greater of: The PPO Allowance shown above or the Medicare rate $50 Copayment</td>
<td></td>
</tr>
<tr>
<td>Urgent Care Center Services</td>
<td>20% of PPO Allowance for Covered Services Deductible waived $50 Copayment</td>
<td>40% of Usual and Reasonable charge for Covered Services $75 Copayment</td>
</tr>
<tr>
<td>Home Care Services Subject to maximum 100 visits per policy year. Home visits for infusion therapy or private duty nursing rendered in the home do not apply to the visit maximum</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Private Duty Nursing in the home Subject to maximum 90 visits per Insured Person per Policy Year</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>BENEFITS FOR COVERED SERVICES</td>
<td>LIMITS AND INSURED’S RESPONSIBILITY NETWORK PROVIDERS</td>
<td>LIMITS AND INSURED’S RESPONSIBILITY NON-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Hospice Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Inpatient and Outpatient Professional Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Inpatient Facility Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Maximum days for Physical Medicine and Rehabilitation (includes day rehabilitation therapy services on an Outpatient basis.)</td>
<td>60 days per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Habilitative/Habilitation Services</td>
<td>60 days per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility Care</td>
<td>90 days per Policy Year</td>
<td></td>
</tr>
<tr>
<td>Mammogram (outpatient)</td>
<td>Please see Preventive Care Services Benefit</td>
<td>Please see Preventive Care Services Benefit</td>
</tr>
<tr>
<td>Routine Mammograms</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Diagnostic Mammograms</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Medical Supplies, Durable Medical Equipment and Appliances (including certain diabetic and asthmatic supplies)</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital/Alternative Care Facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Outpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician Home Visits and Other Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner Visits and Other Services</td>
<td>0% of PPO Allowance for Covered Services Deductible waived $20 Copayment</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Specialty Care Physicians</td>
<td>0% of PPO Allowance for Covered Services Deductible waived $20 Copayment</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Online Clinical Visits</td>
<td>0% of PPO Allowance for Covered Services Deductible waived $20 Copayment</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Preventive Care Services</td>
<td>0% of the PPO Allowance</td>
<td>40% of Usual and Reasonable charge</td>
</tr>
<tr>
<td>Surgical Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>BENEFITS FOR COVERED SERVICES</td>
<td>LIMITS AND INSURED’S RESPONSIBILITY NETWORK PROVIDERS</td>
<td>LIMITS AND INSURED’S RESPONSIBILITY NON-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Temporomandibular or Craniomandibular Joint Disorder/Jaw Disorder</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td><strong>Therapy Services</strong>&lt;br&gt;Home Care Services are paid under that benefit, not the Therapy Services benefit.&lt;br&gt;Physical Therapy - 20 visits combined for Physician Home Visits, office visits, and outpatient visits.&lt;br&gt;Speech Therapy - 20 visits combined for Physician Home Visits, office visits, and outpatient visits.&lt;br&gt;Occupational Therapy - 20 visits combined for Physician Home Visits, office visits, and outpatient visits.&lt;br&gt;Manipulation Therapy - 12 visits combined for Physician Home Visits, office visits, and outpatient visits.&lt;br&gt;Cardiac Rehabilitation - 36 visits combined for Physician Home Visits, office visits, and outpatient visits.&lt;br&gt;Pulmonary Rehabilitation - 20 visits combined for Physician Home Visits, office visits, and outpatient visits.</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation Services</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td><strong>Vision Care Services</strong>&lt;br&gt;Pediatric Vision Care</td>
<td>To the extent considered a Preventive Service, will be paid as a Preventive Service.</td>
<td>To the extent considered a Preventive Service, will be paid as a Preventive Service.</td>
</tr>
<tr>
<td>Low Vision Services</td>
<td>Routine and Preventive Vision Care paid as a Preventive Service. One set of prescription lenses or contact lenses in any 12-month period, one pair of standard frames in any 12-month period.</td>
<td>0% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Other Vision Services</td>
<td>One comprehensive exam every 5 years.&lt;br&gt;High power spectacles, magnifiers, and telescopes. Four exams every 5 years.</td>
<td>0% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Vision Care Services</td>
<td>0% of PPO Allowance for Covered Services</td>
<td>0% of Usual and Reasonable charge for Covered Services</td>
</tr>
</tbody>
</table>
# BENEFITS FOR COVERED SERVICES

<table>
<thead>
<tr>
<th>Medical Service</th>
<th>Limits and Insured’s Responsibility Network Providers</th>
<th>Limits and Insured’s Responsibility Non-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Human Organ and Tissue Transplant (Bone Marrow/Stem Cell)</td>
<td>20% of PPO Allowance for Covered Services</td>
<td>40% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td>Unrelated donor searches for bone marrow/stem cell transplants for a Covered Transplant Procedure</td>
<td>20% of PPO Allowance for Medically Necessary expenses incurred.</td>
<td>40% of Medically Necessary expenses incurred.</td>
</tr>
<tr>
<td>Transportation and Lodging up to $10,000 per transplant.</td>
<td>0% of PPO Allowance for Medically Necessary expenses incurred.</td>
<td>0% of Medically Necessary expenses incurred.</td>
</tr>
<tr>
<td>Unrelated Donor Search up to $30,000 per transplant</td>
<td>0% of PPO Allowance for Medically Necessary expenses incurred.</td>
<td>50% of Medically Necessary expenses incurred.</td>
</tr>
<tr>
<td>Live Donor Health Services – limited to benefits not available to the donor from any other source for up to six weeks from the date of procurement</td>
<td>20% of PPO Allowance for Medically Necessary expenses incurred.</td>
<td>40% of the Maximum Allowable Amount for Medically Necessary live organ donor expenses. Charges do not apply to the Out of Pocket Expense Limit.</td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>0% of PPO Allowance for Covered Services</td>
<td>50% of Usual and Reasonable charge for Covered Services</td>
</tr>
<tr>
<td></td>
<td>Generic Copayment: $15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Copayment: $45</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Brand Copayment: $75</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty Drug Copayment: $75</td>
<td></td>
</tr>
</tbody>
</table>

# OPTIONAL RIDERS

<table>
<thead>
<tr>
<th>Rider Description</th>
<th>Benefit Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Emergency treatment outside the United States Rider Up to $1,000 per Policy Year</td>
<td>40% Usual and Reasonable charge</td>
</tr>
<tr>
<td>Accidental Death and Dismemberment Rider</td>
<td>Principal Sum - $10,000</td>
</tr>
<tr>
<td>Medical Evacuation Expense</td>
<td>100% of Usual and Reasonable Charges</td>
</tr>
<tr>
<td>Repatriation Expense</td>
<td>100% of Usual and Reasonable Charges</td>
</tr>
</tbody>
</table>

# Accidental Death and Dismemberment

## ACCIDENTAL DEATH AND DISMEMBERMENT

If, as the result of a covered Accident, an Insured Person sustains any of the following losses, We will pay the benefit shown below. The loss must occur with 180 days of the date of a covered Accident.

Only one benefit will be payable, that providing the largest benefit, when more than one loss occurs as the result of any one Accident. This benefit is payable in addition to any other benefits payable under the Policy.

- Principal Sum: $10,000.00
- Loss of Life: $10,000.00
- Loss of hand: $5,000.00
- Loss of foot: $5,000.00
- Loss of either one hand, one foot or sight of one eye: $5,000.00
- Loss of more than one of the above losses due to one Accident: $10,000.00
Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The principal sum is the largest amount payable under this benefit for all losses resulting from any one Accident.

Medical Evacuation Benefit

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 the 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 of Remains Benefit

Repatriation Expense - If the Insured Person dies while he or she is covered under the 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.

Non-Covered Services/Exclusions

The following section indicates items which are excluded from benefit consideration, and are not considered Covered Services. Excluded items will not be covered even if the service, supply, or equipment would otherwise be considered Medically Necessary. This information is provided as an aid to identify certain common items which may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such items considered not to be Covered Services. We are the final authority for determining if services or supplies are Medically Necessary.

We do not provide benefits for procedures, equipment, services, supplies or charges:

• Which We determine are not Medically Necessary or do not meet Our medical policy, clinical coverage guidelines, or benefit policy guidelines.
• Received from an individual or entity that is not a Provider, as defined in this Certificate, or recognized by Us.
• Which are Experimental/Investigative or related to such, whether incurred prior to, in connection with, or subsequent to the Experimental/Investigative service or supply, as determined by Us. The fact that a service is the only available treatment for a condition will not make it eligible for coverage if We deem it to be Experimental/Investigative.
• For any condition, disease, defect, ailment, or injury arising out of and in the course of employment if benefits are available under any Workers’ Compensation Act or other similar law. If Workers’ Compensation Act benefits are not available to an Insured Person, then this Exclusion does not apply. This exclusion applies if he or she receives the benefits in whole or in part. This exclusion also applies whether or not the Insured Person claims the
benefits or compensation. It also applies whether or not the Insured Person recovers from any third party.

- To the extent that they are provided as benefits by any governmental unit, unless otherwise required by law or regulation.
- For any illness or injury that occurs while serving in the armed forces, including as a result of any act of war, declared or undeclared.
- For a condition resulting from direct participation in a riot, civil disobedience, nuclear explosion, or nuclear accident.
- For court ordered testing or care unless Medically Necessary.
- For which an Insured Person has no legal obligation to pay in the absence of this or like coverage.
- For the following:
  - Physician or Other Practitioners’ charges for consulting with Insured Persons by telephone, facsimile machine, electronic mail systems or other consultation or medical management service not involving direct (face-to-face) care with the Insured Person except as otherwise described in this Certificate.
  - Surcharges for furnishing and/or receiving medical records and reports.
  - Charges for doing research with Providers not directly responsible for an Insured Person’s care.
  - Charges that are not documented in Provider records.
  - Charges from an outside laboratory or shop for services in connection with an order involving devices (e.g., prosthetics, orthotics) which are manufactured by that laboratory or shop, but which are designed to be fitted and adjusted by the attending Physician.
  - For membership, administrative, or access fees charged by Physicians or other Providers. Examples of administrative fees include, but are not limited to, fees charged for educational brochures or calling a patient to provide their test results.
  - Received from a dental or medical department maintained by or on behalf of a School, mutual benefit association, labor union, trust or similar person or group.
  - Prescribed, ordered or referred by or received from a member of an Insured Person’s immediate family, including an Insured Person’s spouse, child, brother, sister, parent, in-law, or self.
  - For completion of claim forms or charges for medical records or reports unless otherwise required by law.
  - For missed or canceled appointments.
  - For mileage, lodging and meals costs, and other Insured Person travel related expenses, except as specifically stated as a Covered Service.
  - For which benefits are payable under Medicare Parts A, B, and/or D or would have been payable if an Insured Person had applied for Parts A, B and/or D, except, as specified elsewhere in this Certificate or as otherwise prohibited by federal law, as addressed in the section titled “Medicare” in General Provisions. For the purposes of the calculation of benefits, if the Insured Person has not enrolled in Medicare Part B, We will calculate benefits as if they had enrolled.
  - Charges in excess of Our Maximum Allowable Amounts.
  - Incurred prior to an Insured Person’s Effective Date.
  - Incurred after the termination date of this coverage except as specified elsewhere in this Certificate.
  - For any procedures, services, equipment or supplies provided in connection with cosmetic services. Cosmetic services are primarily intended to preserve, change or improve an Insured Person’s appearance or are furnished for psychiatric or psychological reasons. No benefits are available for surgery or treatments to change the texture or appearance of an Insured Person’s skin or to change the size, shape or appearance of facial or body features (such as an Insured Person’s nose, eyes, ears, cheeks, chin, chest or breasts). Complications directly related to cosmetic services treatment or surgery, as determined by Us, are not covered. This exclusion applies even if the original cosmetic services treatment or surgery was performed while the Insured Person was covered by another carrier/self funded plan prior to coverage under this Certificate. Directly related means that the treatment or surgery occurred as a direct result of the cosmetic services treatment or surgery and would not have taken place in the absence of the cosmetic services treatment or surgery. This exclusion does not apply to conditions including but not limited to: myocardial infarction; pulmonary embolism; thrombophlebitis; and exacerbation of co-morbid conditions.
  - For maintenance therapy, which is treatment given when no additional progress is apparent or expected to occur. Maintenance therapy includes treatment that preserves an Insured Person’s present level of functioning and prevents loss of that functioning, but which does not result in any additional improvement.
  - For the following:
    - Custodial Care, convalescent care or rest cures.
• Domiciliary care provided in a residential institution, (except for Mental Health Disorder and Substance Use Disorder treatment), treatment center, halfway house, or school because an Insured Person's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
• Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.
• Care provided or billed by a residential facility (except for Mental Health Disorder and Substance Use Disorder treatment), including observation and assessment by a Provider weekly or more frequently, an individualized program of rehabilitation, therapy, education, and recreational or social activities.
• Services or care provided or billed by a school, Custodial Care center for the developmentally disabled, or outward bound programs, even if psychotherapy is included.
• Wilderness camps.
  • For routine foot care (including the cutting or removal of corns and calluses); Nail trimming, cutting or debriding; Hygienic and preventive maintenance foot care, including but not limited to:
    • cleaning and soaking the feet.
    • applying skin creams in order to maintain skin tone.
    • other services that are performed when there is not a localized illness, injury or symptom involving the foot.
  • For surgical treatment of flat feet; subluxation of the foot; weak, strained, unstable feet; tarsalgia; metatarsalgia; hyperkeratoses.
• Weight loss programs, whether or not they are pursued under medical or Physician supervision, unless specifically listed as covered in this Certificate. This exclusion includes, but is not limited to, commercial weight loss programs (Weight Watchers, Jenny Craig, LA Weight Loss) and fasting programs.
• For bariatric surgery, regardless of the purpose it is proposed or performed. This includes but is not limited to Roux-en-Y (RNY), Laparoscopic gastric bypass surgery or other gastric bypass surgery (surgical procedures that reduce stomach capacity and divert partially digested food from the duodenum to the jejunum, the section of the small intestine extending from the duodenum), or Gastroplasty, (surgical procedures that decrease the size of the stomach), or gastric banding procedures. Complications directly related to bariatric surgery that results in an Inpatient stay or an extended Inpatient stay for the bariatric surgery, as determined by Us, are not covered. This exclusion applies when the bariatric surgery was not a Covered Service under this Plan or any previous National Guardian Life plan, and it applies if the surgery was performed while the Insured Person was covered by a previous carrier/self-funded plan prior to coverage under this Certificate. Directly related means that the Inpatient stay or extended Inpatient stay occurred as a direct result of the bariatric procedure and would not have taken place in the absence of the bariatric procedure. This exclusion does not apply to conditions including but not limited to: myocardial infarction; excessive nausea/vomiting; pneumonia; and exacerbation of comorbid medical conditions during the procedure or in the immediate post-operative time frame.
  • For marital counseling.
  • For hearing aids or examinations to prescribe/fit them, unless otherwise specified within this Certificate.
  • For services or supplies primarily for educational, vocational, or training purposes, except as otherwise specified herein.
  • For services to reverse voluntarily induced sterility.
  • For diagnostic testing or treatment related to infertility.
  • For personal hygiene, environmental control, or convenience items including but not limited to:
    • Air conditioners, humidifiers, air purifiers;
    • Personal comfort and convenience items during an Inpatient stay, including but not limited to daily television rental, telephone services, cots or visitor’s meals;
    • Charges for non-medical self-care except as otherwise stated;
    • Purchase or rental of supplies for common household use, such as water purifiers;
    • Allergenic pillows, cervical neck pillows, special mattresses, or waterbeds;
    • Infant helmets to treat positional plagiocephaly;
    • Safety helmets for Insured Persons with neuromuscular diseases; or
    • Sports helmets.
  • Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a Physician. This exclusion also applies to health spas.
• For telephone consultations or consultations via electronic mail or internet/web site, except as required by law, or as otherwise described in this Certificate.
• For care received in an emergency room which is not Emergency Care, except as specified in this Certificate. This includes, but is not limited to suture removal in an emergency room.
• For eye surgery to correct errors of refraction, such as near-sightedness, including without limitation LASIK, radial keratotomy or keratomileusis or excimer laser refractive keratectomy.
• For self-help training and other forms of non-medical self-care, except as otherwise provided in this Certificate.
• For examinations relating to research screenings.
• For stand-by charges of a Physician.
• Physical exams and immunizations required for enrollment in any insurance program, as a condition of employment, for licensing, or for other purposes except as required under Preventive Services.
• For Private Duty Nursing Services rendered in a Hospital or Skilled Nursing Facility; Private Duty Nursing Services are Covered Services only when provided through the Home Care Services benefit as specifically stated in the "Covered Services" section.
• For Manipulation Therapy services rendered in the home as part of Home Care Services.
• Services and supplies related to sex transformation and/or the reversal thereof, or male or female sexual or erectile dysfunctions or inadequacies, regardless of origin or cause. This Exclusion includes sexual therapy and counseling. This exclusion also includes penile prostheses or implants and vascular or artificial reconstruction, Prescription Drugs, and all other procedures and equipment developed for or used in the treatment of impotency, and all related Diagnostic Testing.
• For (services or supplies related to) alternative or complementary medicine. Services in this category include, but are not limited to, acupuncture, holistic medicine, homeopathy, hypnosis, aroma therapy, massage and massage therapy, reiki therapy, herbal, vitamin or dietary products or therapies, naturopathy, thermograph, orthomolecular therapy, contact reflex analysis, bioenergial synchronization technique (BEST), iridology-study of the iris, auditory integration therapy (AIT), colonic irrigation, magnetic innervation therapy, electromagnetic therapy, and neurofeedback.
• For any services or supplies provided to a person not covered under the Certificate in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).
• For surgical treatment of gynecomastia.
• For treatment of hyperhidrosis (excessive sweating).
• Complications directly related to a service or treatment that is a non-Covered Service under this Certificate because it was determined by Us to be Experimental/Investigational or non-Medically Necessary. Directly related means that the service or treatment occurred as a direct result of the Experimental/Investigational or non-Medically Necessary service and would not have taken place in the absence of the Experimental/Investigational or non-Medically Necessary service.
• For Drugs, devices, products, or supplies with over the counter equivalents and any Drugs, devices, products, or supplies that are therapeutically comparable to an over the counter Drug, device, product, or supply.
• Sclerotherapy for the treatment of varicose veins of the lower extremities including ultrasonic guidance for needle and/or catheter placement and subsequent sequential ultrasound studies to assess the results of ongoing treatment of varicose veins of the lower extremities with sclerotherapy.
• Treatment of telangiectatic dermal veins (spider veins) by any method.
• Reconstructive services except as specifically stated in the Covered Services section of this Certificate, or as required by law.
• Nutritional and/or dietary supplements, except as provided in this Certificate or as required by law. This exclusion includes, but is not limited to, those nutritional formulas and dietary supplements that can be purchased over the counter, which by law do not require either a written Prescription or dispensing by a licensed Pharmacist.

Coordination of Benefits

The Policy contains a coordination of benefits provision. It will coordinate benefits with any other valid and collectible insurance a student may have, including HMO’s and PPO’s.
Subrogation and Reimbursement

We have the right to recover payments We make on an Insured Person’s behalf from any party responsible for compensating an Insured Person for an Insured Person’s injuries. The following apply:

Subrogation

We have the right to recover payments We make on an Insured Person’s behalf from any party responsible for compensating an Insured Person for an Insured Person’s injuries. The following apply:

- We have first priority for the full amount of benefits We have paid from any Recovery. If the Recovery amount is less than the full amount We are due, our portion of the Recovery amount will be diminished in the proportion as the Insured Person’s portion. If there is a dispute regarding the distribution of the Recovery, We or the Insured Person may file an action to resolve the issue of the distribution of the recover.
- The Insured Person and his or her legal representative must do whatever is necessary to enable Us to exercise Our rights and do nothing to prejudice them.
- We have the right to take whatever legal action We see fit against any party or entity to recover the benefits paid under this Certificate.
- To the extent that the total assets from which a Recovery is available are insufficient to satisfy in full Our subrogation claim and any claim still held by the Insured Person, Our subrogation claim shall be first satisfied before any part of a Recovery is applied to an Insured Person’s claim, an Insured Person’s attorney fees, other expenses or costs.
- We are not responsible for any attorney fees, other expenses or costs the Insured Person incurred without Our prior written consent. We further agree that the “common fund” doctrine does not apply to any funds recovered by any attorney the Insured Person hires regardless of whether funds recovered are used to repay benefits paid by Us.

Reimbursement: If an Insured Person obtains a Recovery and We have not been repaid for the benefits We paid on an Insured Person’s behalf, We shall have a right to be repaid from the Recovery in the amount of the benefits paid on an Insured Person’s behalf and the following apply:

- He or she must reimburse Us to the extent of benefits We paid on an Insured Person’s behalf from any Recovery.
- Notwithstanding any allocation made in a settlement agreement or court order, We shall have a right of Recovery, in first priority, against any Recovery.
- The Insured Person and his or her legal representative must hold the proceeds of the gross Recovery (i.e., the total amount of an Insured Person’s Recovery before attorney fees, other expenses or costs) to be paid to Us immediately upon an Insured Person’s receipt of the Recovery. Such Insured must reimburse Us, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The “common fund” doctrine does not apply to any funds recovered by any attorney an Insured Person hires regardless of whether funds recovered are used to repay benefits paid by Us.
- If he or she fails to repay Us, We shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of an Insured Person’s Recovery whichever is less, from any future benefit under the Plan if:
  1. The amount We paid on an Insured Person’s behalf is not repaid or otherwise recovered by Us; or
  2. He or she fails to cooperate.
- In the event that the Insured Person fails to disclose to Us the amount of an Insured Person’s settlement, We shall be entitled to deduct the amount of Our lien from any future benefit under the Plan.
- We shall also be entitled to recover any of the unsatisfied portion of the amount We have paid or the amount of an Insured Person’s settlement, whichever is less, directly from the Providers to whom We have made payments. In such a circumstance, it may then be an Insured Person’s obligation to pay the Provider the full billed amount, and We would not have any obligation to pay the Provider.
- We are entitled to reimbursement from any Recovery, in first priority, even if the Recovery does not fully satisfy the judgment, settlement or underlying claim for damages or fully compensate or make the Insured Person whole.
Right of Recovery

Whenever payment has been made in error, We will have the right to recover such payment from an Insured Person or, if applicable, the Provider. In the event We recover a payment made in error from the Provider, except in cases of fraud, We will only recover such payment from the Provider during the 24 months after the date We made the payment on a claim submitted by the Provider. We reserve the right to deduct or offset any amounts paid in error from any pending or future claim. The cost share amount shown in an Insured Person’s Explanation of Benefits is the final determination and an Insured Person will not receive notice of an adjusted cost share amount as a result of such recovery activity.

We have oversight responsibility for compliance with Provider and vendor and Subcontractor contracts. We may enter into a settlement or compromise regarding enforcement of these contracts and may retain any recoveries made from a Provider, Vendor, or Subcontractor resulting from these audits if the return of the overpayment is not feasible. We have established recovery policies to determine which recoveries are to be pursued, when to incur costs and expenses and settle or compromise recovery amounts. We will not pursue recoveries for overpayments if the cost of collection exceeds the overpayment amount. We may not provide an Insured Person with notice of overpayments made by Us or the Insured Person if the recovery method makes providing such notice administratively burdensome.

Claim Procedures

In the event of either an Injury or a Sickness:
1. Report to a Physician, Hospital or the School’s Student Health Services.
2. Written notice of a claim must be submitted to the address below within ninety (90) days after the date of Injury or commencement of Sickness covered by the Policy, or as soon thereafter as is reasonably possible.
3. Mail to the address below all medical and hospital bills along with the patient’s name and insured student’s name, address, Social Security number or student ID number and name of the University under which the student is insured. A Company claim form is not required for filing a claim. Bills should be received by the Company within ninety (90) days of service. Bills submitted after one year will not be considered for payment except in the absence of legal capacity.

CIGNA
PO Box 188061
Chattanooga, TN 37422 – 8061
Electronic Payor ID: 62308

For information about the Cigna Prescription Drug Program please visit www.cigna.com.

Claim Appeals and Administration

Once a claim is processed and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person may request an appeal in writing within one hundred eighty (180) days of the date appearing on the EOB. The appeal request must include why the Insured Person disagrees with the way the claim was processed. The request must include any additional information he/she feels supports the request for appeal, e.g. medical records, physician records, etc. Please submit all Claim Appeal requests to Consolidated Health Plans.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5030
www.chpstudent.com
Group Number: ST0862SH
This plan is underwritten by:
National Guardian Life Insurance Company
Madison, WI

As Policy form: NBH-280 (2014) cb OH Rev 3-16 et al

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

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

Representations of the Plan must be approved by the Company.

This is not the Policy. Rather, it is a brief description of the benefits and other provisions of the Policy. The Policy is governed by the laws and regulations of the state in which it is issued and is subject to any necessary State approvals. Any provisions of the Policy, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state’s laws, including those relating to mandated benefits.

Value Added Services

The following services are not part of the Plan Underwritten by National Guardian Life Insurance Company. These value added options are provided by Consolidated Health Plan.

### VISION DISCOUNT PROGRAM
For Vision Discount Benefits please go to:
www.chpstudent.com

### EMERGENCY MEDICAL AND TRAVEL ASSISTANCE
Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-877-657-5030. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 or if you are in a foreign country, call collect at: 715.295.9311.**
When you call, please provide your name, school name, the group number shown on your id card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour assistance center.
Students who enroll and maintain medical coverage in this insurance plan have access to a 24-hour nurse line administered by Ask Mayo Clinic. This program provides:

• Phone-based, reliable health information in response to health concerns and questions; and
• Assistance in decisions on the appropriate level of care for an injury or sickness.

Appropriate care may include self-care at home, a call to a physician, or a visit to the emergency room.

Calls are answered 24 hours a day, 365 days a year by experienced registered nurses who have been specifically trained to handle telephone health inquiries.

This program is not a substitute for doctor visits or emergency response systems. Ask Mayo Clinic does not answer health plan benefit questions. Health benefit questions should be referred to the Plan Administrator. The Ask Mayo Clinic 24-hour nurse line toll free number will be on the ID card.

Your out-of-pocket costs may be lower when you utilize Cigna PPO Providers. For a listing of Cigna PPO Providers, go to www.cigna.com or contact Consolidated Health Plans toll-free at (877) 657-5030, or www.chpstudent.com for assistance.