Student Health Insurance Plan

Designed for International Students and Scholars Attending

Maharishi University of Management

Student Health Insurance Plan Designed for International Students and Scholars Attending Maharishi University of Management 2016 - 2017

Underwritten by:
National Guardian Life Insurance Company
Madison, WI

Policy Number: 2016I5B56
Group Number: S218716

Effective: 8/1/16 - 7/31/17

Administered by:

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, SAS/Ryan Desch at 651-439-7098, Email: ryand@sas-mn.com, or Consolidated Health Plans at 800-633-7867. If you need assistance resolving a complaint, please contact Us at: 1-800-756-3702.

COVERAGE

1. Accident and Sickness coverage begins on August 1, 2016, or the date of enrollment in the plan, whichever is later and ends July 31, 2017.
2. Benefits are payable during the Policy Term, subject to any Extension of Benefits.
3. Should a student graduate or leave College for any reason, except to enter military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.
4. The Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. The 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.

CERTIFICATE OF
STUDENT HEALTH INSURANCE POLICY
issued by
NATIONAL GUARDIAN LIFE INSURANCE COMPANY, PO BOX 1191, Madison, WI 53701-1191
(Herein referred to as ‘We’, ‘Us’ or ‘Our’)

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2014) IA (“the Policy”).

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**Section 1 — Definitions**

The terms listed below, if used in this Certificate, have the meanings stated.

**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.

**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 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.

**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 or stepchild 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.

**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 (except Medically Necessary bariatric surgery), infertility (except as covered under the Infertility Services benefit) 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** mean 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, drug addicts or alcoholics.

**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.

**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 Illness** means a clinically significant disorder of thought, mood,
perception, orientation, memory or behavior which:
1. Is listed in the most recent edition of the clinical manual of the International Classification of Diseases, ICD-9-CM, code range 295 to 302.9, inclusive, 306 to 309.9, inclusive, or 311 to 316, inclusive, or the corresponding code in the most recent edition of the American Psychiatric Association’s Diagnostic and Statistical Manual of Mental Disorders, DSM-IV, Axis I; and
2. Seriously limits the capacity of an Insured Person to function in the primary aspects of daily living, including, without limitation, personal relations, living arrangements, employment and recreation.

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

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

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

**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.

**Prescription Care** means medications prescribed by a licensed Physician and any health-related services deemed Medically Necessary to determine the need or effectiveness of the medications.

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

**Skilled Nursing Facility** means a licensed institution devoted to providing medical, nursing, or custodial care for an Insured Person over a prolonged period, such as during the course of a chronic disease or the rehabilitation phase after an acute sickness or injury.

**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.

**Specialty Drugs** means drugs that are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the Insured Person’s drug therapy.

**Stabilize** means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**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.

**Treatment Plan** as it applies to the Autism Benefit means a plan to treat an autism spectrum disorder that is prescribed by a licensed Physician or licensed psychologist and may be developed pursuant to a comprehensive evaluation in coordination with a Licensed Behavior Analyst.

**Usual and Reasonable (U&R)** 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.

**You, Your** means a student of the Policyholder who is eligible and insured for coverage under the policy.
Section 2 – Eligibility, Enrollment and Termination
All full-time and part-time international students and scholars enrolled in or teaching a degree-granting program are required to have health insurance coverage. Students and scholars are automatically enrolled in the insurance plan. The premium is collected and paid by the University. Eligible dependents may enroll on a voluntary basis. Dependents must enroll for the same period the student enrolls.

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).

<table>
<thead>
<tr>
<th>Dependent Coverage</th>
<th>Annual* 8/1/16 – 7/31/17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$2,036</td>
</tr>
<tr>
<td>Spouse</td>
<td>$2,036</td>
</tr>
<tr>
<td>Each Child</td>
<td>$2,036</td>
</tr>
<tr>
<td>3 or more Children</td>
<td>$6,108</td>
</tr>
</tbody>
</table>

Dependent rates are in addition to the student rate.

Dependent Coverage - 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).

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.

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.

Extension of Benefits: Coverage under the Policy ceases on the Termination Date. 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 a minimum of 90 days from the Termination Date while such confinement continues.

Section 3—BENEFITS
Benefits are payable under the policy only for those Covered Medical Expenses incurred while the Policy is in effect as to the Insured Person. The Covered Medical Expenses for an issued Policy will be only those listed in the Schedule of Benefits. 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. Subject to payment of any required Deductible, when you suffer a Loss from Covered Accident or Covered Sickness, we will pay benefits as follows:

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; 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.

Treatment of Covered Injury or Covered Sickness: We will pay benefits for the Usual and Reasonable Charges for Covered Medical Expenses that are incurred by the Insured Person 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; 6) the Exclusions and Limitations provision.
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.

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 Limit. However, the Insured Person’s Coinsurance amounts, Deductibles and Copays will apply toward the Out-of-Pocket Limit.

See NPPO(2014) IA at the end of this Certificate.

Covered Medical Expenses

We will pay the Usual and Reasonable charges incurred for 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. 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;
   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 - We will pay the charges 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 – We will pay the expenses incurred for Physician’s visits 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 Assistant Surgeon Services, and Organ Transplant - We will pay benefits for inpatient surgery (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. Coverage for organ transplants includes the following: certain bone marrow and stem cell transfers, heart, heart and lung, kidney, liver, lung, pancreas, and small bowel. Expenses of transporting a living donor, expenses related to the purchase of any organ, services or supplies related to mechanical or non-human organs associated with transplants, are not covered.
7. Registered Nurse’s Services, when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.
8. Physical Therapy while Confined – We will pay the expenses incurred for physical therapy when prescribed by the attending physician.
9. Skilled Nursing Facility Expense Benefit - the expenses incurred for the services, supplies and treatments rendered to an Insured Person by a Skilled Nursing Facility. The Insured Person must enter a Skilled Nursing Facility:
   a. Within seven (7) days after his/her discharge from a Hospital confinement;
   b. Such confinement must be of at least three (3) consecutive days that
began while coverage was in force under this Policy; and

3. Was for the same or related Sickness or Accident;

Services, supplies and treatments by a Skilled Nursing Facility include:

1. Charges for room, board and general nursing services;
2. Charges for physical, occupational or speech therapy;
3. Charges for drugs, biologicals, supplies, appliances and equipment for use in such facility, which are ordinarily furnished by the Skilled Nursing Facility for the care and treatment of a confined person, and
4. Charges for medical services of interns, in training, under a teaching program of a Hospital with which the facility has an agreement for such services.

**Outpatient Benefits**

1. **Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** - We will pay benefits 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.

Benefits for Bariatric Surgery are limited to the benefit shown in the Schedule of Benefits and include gastric restrictive surgery services for extreme obesity under the following circumstances only. The Insured Person must have a body mass index (BMI) of greater than 40kg/m2 or have a BMI greater than 35kg/m2 with significant co-morbidities. The Insured Person must provide acceptable documented evidence that dietary attempts at weight control are ineffective and be at least 18 years old. Attendance at a medically supervised weight loss program within the last 24 months for at least three (3) months is required with documented failure of weight loss.

2. **Outpatient Surgery Miscellaneous** - (excluding non-scheduled surgery) surgery performed in a hospital emergency room, trauma center, physician’s office, outpatient 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 plasma; and
   e. Miscellaneous supplies.

3. **Outpatient Facility Fee** – We will pay the expenses for outpatient facilities, including an ambulatory surgical center, for outpatient surgery and ancillary supplies and services.

4. **Rehabilitation Therapy** – When prescribed by the attending Physician covers physical and occupational and manipulative therapy, as well as cardiac rehabilitation, for treatment of a Covered Injury or Covered Sickness. Limited to one visit per day.

5. **Rehabilitative Speech Therapy** – When prescribed by the attending Physician for treatment of a specific sickness, injury, or impairment, as shown in the Schedule of Benefits above. Speech therapy services not provided by a licensed or certified speech pathologist, and speech therapy to treat certain developmental, learning, or communication disorders such as stuttering and stammering are not covered.

6. **Chiropractic Care** – For treatment of a Covered Injury or Covered Sickness and performed by a Physician.

7. **Emergency Services Expenses** - Only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

5. **In Office Physician’s Visits** – We will pay the expenses incurred 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.

6. **Diagnostic Tests** – We will provide coverage for diagnostic tests, screenings, imagings, and evaluation procedures as Medical Necessary, including X-ray services, CT/PET Scans, and MRIs, as shown in the Schedule of Benefits when prescribed by a physician. Under this benefit, hearing exams are only covered in the case of an covered sickness or injury.

7. **Laboratory Procedures (Outpatient)** – We will provide coverage for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

8. **Prescription Drugs** -
   a. We will pay the expenses incurred 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. Also covered are prescribed contraceptives and hormone replacement therapies.
   b. **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:
   i. The drug is approved by the FDA;
   ii. The drug is prescribed for the treatment of a life-threatening condition including cancer;
   iii. 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”; or
      (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 i., ii., and iii. 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.

c. Specialty Drugs – “Specialty Drugs” are Prescription drugs which:
   1. Are only approved to treat limited patient populations indication or conditions; or
   2. Are normally injected, infused or require close monitoring by a Physician or a 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) - We will pay the charges actually incurred 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 - We will pay the charges incurred for Home Health Care for an Insured Person when approved by a Physician and when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary. Benefits include private duty nursing in addition to care by a home health aide according to a treatment plan prescribed by a qualified Physician. Home Health Care visits related to maternity care will be payable under the Maternity Benefit and not this Benefit.

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. We will also pay for 5 bereavement sessions provided to Immediate Family Members as long as they are provided within six (6) months of the Insured Person’s death.

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 — We will pay the expenses incurred for transportation to or from a Hospital by ground and air ambulance. Subject to the Claims Provisions, We will provide for the direct reimbursement of a provider of medical transportation for covered services if that provider does not receive reimbursement from any other source.

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 prosthetics or orthotics when
used as protective devices during a student’s participation in sports. Replacement prosthetics and orthotics are not covered.

3. **Durable Medical Equipment** - We will pay the expense incurred 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.

This benefit shall also cover diabetics supplies as well as medically necessary prosthetic devices, such as an artificial limb or device to replace, in whole or in part, an arm or leg.

4. **Maternity Benefit** - We will pay the expenses incurred for prenatal care and maternity charges as follows:
   a. **Prenatal and Postnatal care**, including pregnancy testing when performed in a Physician’s office.
   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 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 obstetrical and nursing professionals.

5. **Routine Newborn Care** - If 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.

6. **Morbid Obesity & Bariatric Surgery Benefit** - We will pay the Usual and Reasonable expenses incurred for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health for the long term reversal of morbid obesity. We will pay these expenses on the same basis as for other medical and surgical procedures.

As used in this Benefit:

Morbid Obesity means:
   a. a weight that is at least 100 pounds over or twice the ideal weight
for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables;

b. a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or

c. a BMI of 40 kilograms per meter squared without comorbidity.

BMI (Body Mass Index) means weight in kilograms divided by height in meters squared.

7. **Habilitation Services** - We will pay the Usual and Reasonable charges incurred for habilitative services driven by congenital disorders or developmental delays.

8. **Pediatric Dental Care** - We will pay the Usual and Reasonable expenses incurred for the following dental care services for Insured Persons 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:

      - Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
      - Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
      - Sealants on unrestored permanent molar teeth; and
      - 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:

      - Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
      - 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);
      - Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
      - In-office conscious sedation;
      - Amalgam, composite restorations and stainless steel crowns; and
      - 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.
      - Prosthodontic services as follows:
      - Removable complete or partial dentures, including six (6) months follow-up care; and
      - 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:

      - 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
      - For cleft palate stabilization; or
      - 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.

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

9. **Pediatric Vision Care** - We will pay the Usual and Reasonable expenses incurred for emergency, preventive and routine vision care for Insured Persons up to age 19.

   a. 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:

      1. Case history;
      2. External examination of the eye or internal examination of the eye;
(3) Ophthalmoscopic exam;
(4) Determination of refractive status;
(5) Binocular distance;
(6) Tonometry tests for glaucoma;
(7) Gross visual fields and color vision testing; and
(8) Summary findings and recommendation for corrective lenses.
b. 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. 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.

10. **Chemotherapy and Radiation Therapy** – We will cover the Usual and Reasonable charges for chemotherapy, oral chemotherapy drugs, and radiation therapy to treat or control a serious illness, as shown in the Schedule of Benefits.

11. **Infusion Therapy** – Infusion Therapy is the administration of Drugs (Prescription substances), by the intravenous (into a vein), intramuscular (into a muscle), subcutaneous (under the skin), and intrathecal (into the spinal canal) routes. For the purpose of this Plan, it shall also include Drugs administered by aerosol (into the lungs) and by feeding tube. Covered Expense for Infusion Therapy (including all professional services, compounding fees, incidental supplies, medications, drugs, solutions, durable medical equipment and training related to Infusion Therapy) will not exceed the Average Wholesale Price as determined by the Insurer or the Negotiated Rate:

   Covered Services for Infusion Therapy are as follows:
   a. Professional services to order, prepare, compound, dispense, deliver, administer, train or monitor (including clinical pharmacy support) any drugs or other substances used in Infusion Therapy.
   b. All necessary supplies and durable medical equipment including, but not limited to, bandages, cotton swabs, intravenous starter kits, tubing, syringes, needles, pump, pole, and electronic monitor.
   c. The Infusion Therapy Drugs or other substances.
   d. Blood transfusions, including blood processing and the cost of unreplaceable blood and blood products.

12. **Reconstructive Surgery** – We will pay the Usual and Reasonable expenses incurred by an Insured Person for reconstructive surgery, primarily to restore function lost or impaired as the result of an Illness, accidental injury, or a birth defect. Coverage includes, but is not limited to reconstructive of the breast on which a mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prosthesis.

13. **Mental/Behavioral Health Services and Substance Abuse Disorder Services Benefit** – We will pay the Usual and Reasonable expenses incurred for mental and behavioral health treatment on the same basis as any other Sickness. This benefit provides coverage for certain psychiatric, psychological, or emotional conditions for which the diagnostic criteria are prescribed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders as follows:
   a. schizophrenia,
   b. bipolar disorder (manic-depressive illness),
   c. major depressive disorder,
   d. panic disorder,
   e. obsessive-compulsive disorder,
   f. schizoaffective disorder,
   g. substance abuse and chemical dependency.

   Autistic Disorders are also covered under this benefit. For purposes of this benefit, an Autistic Disorder means a neurological disorder that is marked by severe impairment in social interaction, communication, and imaginative plan, with onset during the first three (3) years of life and is included in a group of disorders known as autism spectrum disorders.

14. **Consultant Physician Services** - When requested and approved by the attending Physician.

15. **Accidental Injury Dental Treatment for Insured Person over age 18** - As the result of Injury. Routine dental care and treatment are not payable under this benefit.

16. **Sports Accident Expense Benefit** – We will pay the expenses incurred by an Insured Student as the result of covered sports accident while at play or practice of intercollegiate or club sports as shown in the Schedule of Benefits.

17. **Abortion Expense** - We will pay the charges for the expense of a voluntary, non-therapeutic, abortion. This benefit will be in lieu of all other Policy benefits and may not exceed the benefit shown in the Schedule of Benefits.

18. **Bedside Visits (International Students and/or their Dependents Only)** - If the Insured Person is Hospital Confined for more than seven (7) continuous days as the result of a Covered Injury or Covered Sickness, We will pay a benefit. We will pay for the cost of an economy round-trip airfare for an individual to travel to the Hospital bedside of the Insured Person. The benefit will not to exceed the amount shown in the Schedule of Benefits. This individual must be designated by the Insured Person and
the trip must be approved by Us. No more than one trip may be made during any one Policy Year.

**Medical Treatment Received in Home Country (International Students and/or their Dependents Only)** - If the Insured Person incurs expenses as the result of treatment for a Covered Injury or Covered Sickness in his or her Home Country, we will pay the expenses incurred not to exceed the amount shown in the Schedule of Benefits.

**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 a 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: 1. an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness; 2. 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: 1. 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; 2. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation; 3. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable; 4. 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; 5. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and 6. 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.

**Non-Emergency Medical Treatment Received When Traveling Outside the United States** - If the Insured Person incurs expenses as the result of treatment for a Covered Injury or Covered Sickness in another country, We will pay the Usual and Reasonable expenses incurred not to exceed the amount shown in the Schedule of Benefits.

**Mandated Benefits for Iowa**

**Mammography Screening** - We will pay the Usual and Reasonable expenses incurred for annual mammography screenings for any insured female thirty-five (35) or older, or more frequently, if recommended by the Insured’s Physician.

**Coverage of Human Papilloma Virus (HPV) Vaccination** - We will pay the Usual and Reasonable Charge for the Human Papilloma Virus (HPV) Vaccination.

**Clinical Trials** - We will pay the Usual and Reasonable expenses incurred for Routine Patient Care Costs incurred for cancer treatment in an Approved Cancer Clinical Trial, to the same extent that coverage is provided for treating any other sickness, injury, disease, or condition covered under the policy, if the Insured has been referred for such cancer treatment by two Physicians who specialize in oncology and the cancer treatment is given pursuant to an approved cancer clinical trial that meets the criteria set forth below.

Routine patient care costs for cancer treatment given pursuant to an approved cancer clinical trial shall be covered if all of the following are met:

- The Treatment is provided with therapeutic intent and is provided pursuant to an approved cancer clinical trial that has been authorized or approved by one of the following:
  1. The National Institutes of Health.
  2. The United States Food and Drug Administration.
  3. The United States Department of Defense.
  4. The United States Department of Veteran Affairs.

- The proposed treatment has been reviewed and approved by the applicable qualified Institutional Review Board

- The available clinical or preclinical data indicate that the treatment that will be provided pursuant to the approved cancer clinical trial will be at least as effective as the standard therapy and is anticipated to constitute an improvement in therapeutic effectiveness for the treatment of the disease in question.
As used in this Benefit:
Approved Cancer Clinical Trial means a scientific study of a new therapy for the treatment of cancer in human beings that meets the requirements described above and consists of a scientific plan of treatment that includes specified goals, a rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions.

Institutional Review Board means a board, committee, or other group formally designated by an institution and approved by the National Institutes of Health, Office for Protection from Research Risks, to review, approve the initiation of, and conduct periodic review of biomedical research involving human subjects.

Routine Patient Care Costs means Medically Necessary services or treatments that are a benefit under a contract or policy providing for third-party payment or prepayment of health or medical expenses that would be covered if the patient were receiving standard cancer treatment.

Routine Patient Care Costs does not include any of the following:
a. Costs of any treatments, procedures, drugs, devices, services or items that are the subject of the approved cancer clinical trial or any other investigational treatments, procedures, drugs, devices, services, or items.
b. Costs of non-healthcare services that the patient is required to receive as a result of participation in the Approved Cancer Clinical Trial.
c. Costs associated with managing the research that is associated with the Approved Cancer Clinical Trial.
d. Costs that would not be covered by the third-party payment provider if non-investigational treatments were provided.
e. Costs of any services, procedures, or tests provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient participating in an Approved Cancer Clinical Trial.
f. Costs paid for, or not charged for, by the Approved Cancer Clinical Trial providers.
g. Costs for transportation, lodging, food, or other expenses for the patient, a family member, or a companion of the patient that are associated with travel to or from a facility where an Approved Cancer Clinical Trial is conducted.
h. Costs for services, items, or drugs that are eligible for reimbursement from a source other than a patient’s contract or policy providing for third-party payment or prepayment of health or medical expenses, including the sponsor of the Approved Cancer Clinical Trial.
i. Costs associated with Approved Cancer Clinical Trials designed exclusively to test toxicity or disease pathophysiology.
j. Costs of extra treatments, services, procedures, tests, or drugs that would not be performed or administered except for participation in the cancer clinical trial.

Dental Coverage for Anesthesia and Hospitalization Benefit – We will pay the Usual and Reasonable expenses for administration of general anesthesia and hospital or ambulatory surgical center charges related to the provision of dental care services provided to an Insured Person who is:
a. a child under five (5) years of age upon a determination by a licensed dentist and the child’s treating physician licensed pursuant to chapter 148, that such child requires necessary dental treatment in a hospital or ambulatory surgical center due to a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective; or
b. any individual upon a determination by a licensed dentist and the individual’s treating physician licensed pursuant to chapter 148, that such individual has one or more medical conditions that would create significant or undue medical risk for the individual in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

We do not pay for the Physician’s expenses unless otherwise covered under federal law.

Diabetes Care Management - When prescribed by a licensed Physician, We will pay the Usual and Reasonable expenses incurred for the following:
a. equipment and supplies;
b. diabetes self-management training and education under all of the following conditions:
   1. the Physician managing the Insured’s diabetic condition certifies that such services are needed under a comprehensive plan of care related to the Insured’s diabetic condition to ensure therapy compliance or to provide the Insured with necessary skills and knowledge to participate in the management of the Insured’s condition.
   2. The diabetes self-management training and education program is certified by the Iowa department of public health.

Section 4 – 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.

The policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of the policy and as shown in the Schedule of Benefits.
1. **International Students Only** - expenses incurred within the Insured Person’s Home Country or country of regular domicile that exceeds the benefit amount shown in the Schedule of Benefits.

2. Medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.

3. Dental treatment or treatment to the teeth including orthodontic braces and orthodontic appliances, except as specified for accidental injury to the Insured Person’s Sound, Natural Teeth or as covered under Pediatric Dental Benefit.

4. Professional services rendered by an Immediate Family Member or any who lives with the Insured Person.

5. Services or supplies not necessary for the medical care of the Insured Person’s Injury or Sickness.

6. Services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental injury or as specifically covered under the Policy.

7. Weak, strained or flat feet, corns, calluses or ingrown toenails.

8. Surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness or as specifically covered under the Infertility Services benefit.

9. 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.

10. Expenses covered under any Workers’ Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.

11. 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.

12. Any expenses in excess of Usual and Reasonable charges.

13. 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.

14. 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.

15. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate or club sports;

16. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;

17. 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.

18. Services that are duplicated when provided by both a certified nurse-midwife and a Physician.

19. Expenses payable under any prior Policy which was in force for the person making the claim.

20. 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.

21. Expenses incurred after:
   a. The date insurance terminates as to the Insured Person;
   b. The Maximum Benefit for each Covered Injury or Covered Sickness has been attained; and
   c. The end of the Benefit Period specified in the Benefit Schedule.

22. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.

23. Charges incurred for acupuncture, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.

24. 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 as specifically covered under the Policy.

25. Ultra light aircraft, parasailing, sail planing, hang gliding.

26. 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.
   a. 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.
   b. 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.

27. An Insured Person’s:
   a. Committing or attempting to commit a felony,
   b. Being engaged in an illegal occupation, or
   c. Participation in a riot.
28. elective abortions in excess of the amount shown in the Schedule of Benefits.
29. congenital defects, except as provided for newborn or adopted children added after the Effective Date of coverage.
30. custodial care, service and supplies.
31. expenses that are not recommended and approved by a Physician.

Section 5 – Claim Procedure
In the event of Accident or Sickness the student should:
1. If at the College, report to Health Services so that proper treatment can be prescribed or approved.
2. If away from the school, consult a doctor and follow his or her advice. Notify Maharishi University of Management within 90 days after the date of the Covered Injury or commencement of the Covered Sickness or as soon thereafter as is reasonably possible.
4. Complete the form.
5. Submit the claim form, complete with bills and receipts, to the Claims Administrator.
6. Submit only one claim form for each Accident or Sickness.

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free: 800-633-7867

Section 6 – Coordination of Benefits
If the Insured Person is insured under more than one group health plan, the benefits of the plan that covers the Insured Student will be used before those of a plan that provides coverage as a dependent Insured Person. When both parents have group health plans that provide coverage as a dependent, the benefits of the plan of the parent whose birth date falls earlier in the year will be used first. The benefits available under this Plan may be coordinated with other benefits available to the Covered Person under any auto insurance, Workers’ Compensation, Medicare, or other coverage. The Plan pays in accordance with the rules set forth in the Policy on file with the Policyholder.

Section 7 - Appeals Procedure
You have the right to appeal any decision or action taken by Us to deny, reduce, or terminate the provision of or payment for health care services requested or received under this Certificate of Insurance. We must provide you with certain written information, including the specific reason for Our decision and a description of Your appeals rights and procedures every time We make a determination to deny, reduce, or terminate the provision of or payment for health care services requested or received under the Certificate of Insurance.

Service Representative:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800-633-7867
www.chpstudent.com

Underwritten by:
National Guardian Life Insurance Company
as policy form # NBH-280 (2014) IA

Administered by:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
www.chpstudent.com
(413) 733-4540

For a copy of the Company’s privacy notice you may:
go to www.chpstudent.com
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 this plan must be approved by Us.

IMPORTANT
THIS CERTIFICATE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE AS DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE AT THE COLLEGE.
The Policy to which this rider is attached is amended as follows:

**BENEFIT PAYMENT FOR NETWORK PROVIDERS AND NON-NETWORK PROVIDERS RIDER**

This Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. 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 (included in this Rider) [attached to the Policy.]

**SECTION I – DEFINITIONS** is amended by the addition of the following definitions:

**Network Providers** are Physicians, Hospitals and other healthcare 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.

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

**SECTION III - DESCRIPTION OF BENEFITS** is amended as follows:

The provision entitled **Treatment of Covered Injury or Covered Sickness** is amended to read:

**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 provision is added:

**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 pay at the PPO Allowance level for treatment by a Non-Network Provider if:

1. there is no Network Provider available to treat the Covered 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.

There are no other changes to the Policy.

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

Kimberly A. Shaul
Secretary

Mark L. Solverud
President

SCHEDULE OF BENEFITS
Platinum 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 and Extension of Benefits – when appropriate.

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 Provider: 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: $0
- Non-Network: $0

Out-of-Pocket Expense Limit:
- Network Provider: $6,850 Individual/$13,700 Family
- Non-Network Provider: No Maximum

Coinsurance:
- Network Provider: 100% of PPO Allowance of Covered Medical Expenses unless otherwise stated below
- Non-Network Provider: 80% of the 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:
Your Network Provider is PHCS at www.phcs.com, or call toll free 800-633-7867 or visit the website 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 OR NOT THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK PROVIDER.

<table>
<thead>
<tr>
<th>BENEFITS FOR 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 Expense - 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</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
</tbody>
</table>

**Inpatient Surgery:**

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<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>Organ Transplant</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Registered Nurse Services for private duty nursing while confined</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Physical Therapy (inpatient)</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</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
</tbody>
</table>

**Outpatient Benefits**

<table>
<thead>
<tr>
<th>Service</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
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<tbody>
<tr>
<td>Surgeon Services</td>
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<td>Anesthetist</td>
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<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>
</tbody>
</table>
### Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Outpatient Facility Fee
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Rehabilitation Therapy (outpatient), including: physical, occupational, and manipulative therapy, as well as cardiac rehabilitation
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Rehabilitative Speech Therapy
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Chiropractic Care
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Emergency Services Expenses
- **100% of PPO Allowance for Covered Medical Expenses**
- **100% of Usual and Reasonable Charge for Covered Medical Expenses**
  - Copay: $150
  - Copay waived if admitted

### In Office Physician’s Visits, including licensed registered nurse’s and licensed physician’s assistant’s Fees:
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**
  - Copay: $30

### Private-Duty Nursing by a Registered Nurse
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Diagnostic Tests
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Laboratory Procedures (Outpatient)
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Prescription Drugs
- **100% of PPO Allowance for Covered Medical Expenses**
- **N/A**
  - Copay: $20 Generic
  - Copay: $40 Preferred Brand
  - Copay: $60 Brand
  - Copay: $60 Specialty Drug
  - See Prescription Card

### Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Home Health Care Expenses
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Hospice Care Coverage
- **The PPO Allowance stated above**
- **The Usual and Reasonable Charge stated above**

### Urgent Care Centers or Facilities
- **100% of PPO Allowance for Covered Medical Expenses**
- **100% of Usual and Reasonable Charge for Covered Medical Expenses**
  - Copay: $30

### Other Benefits

**Ambulance Service**
- **100% of PPO Allowance for Covered Medical Expenses**
- **80% of Usual and Reasonable Charge for Covered Medical Expenses**
<table>
<thead>
<tr>
<th>Braces and Appliances</th>
<th>The PPO Allowance stated above</th>
<th>The Usual and Reasonable Charge stated above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Durable Medical Equipment</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Maternity Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Morbid Obesity &amp; Bariatric Surgery Benefit</td>
<td>Same as any other Covered Sickness and Surgery</td>
<td>Same as any other Covered Sickness and Surgery</td>
</tr>
<tr>
<td>Habilitation Services</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Pediatric Dental Preventive Dental Care</td>
<td>See Benefit for limitations 100%, limited to 1 dental exams every 6 months</td>
<td>See Benefit for limitations 100%, limited to 1 dental exams every 6 months</td>
</tr>
<tr>
<td>Emergency Dental</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Clinical Oral Evaluations</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Endodontic Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Periodontal Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Prosthodontic Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Medically Necessary Orthodontic Care</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Pediatric Vision limited to 1 visit per Policy Year and 1 pair of prescribed lenses and frames</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Chemotherapy and Radiation Therapy</th>
<th>The PPO Allowance stated above</th>
<th>The Usual and Reasonable Charge stated above</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infusion Therapy</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Reconstructive Surgery</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Mental/Behavioral Health Services and Substance Abuse Disorder Services Benefit</td>
<td>Same as any other Covered Sickness</td>
<td>Same as any other Covered Sickness</td>
</tr>
<tr>
<td>Consultant Physician Services – when requested by the attending physician</td>
<td>The PPO Allowance stated above Copay: $30</td>
<td>The Usual and Reasonable Charge stated above Copay: $30</td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment for Insured Person’s over age 18</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Sports Accident Expense - incurred as the result of the play or practice of intramural or club sports</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Abortion Expense</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Bedside Visits (International Students and/or their Dependents Only)</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
</tbody>
</table>
### Medical Evacuation Expense
- (International Students and/or their Dependents and Domestic Student participating in a study abroad program)

- subject to $50,000 maximum per Policy Year

### Repatriation Expense
- (International Students and/or their Dependents and Domestic Student participating in a study abroad program)

- subject to $50,000 maximum per Policy Year

### Non-Emergency Medical Treatment Received When Traveling Outside the United States

- 80% of Usual and Reasonable Charge for Covered Medical Expenses

### Mandated Benefits

<table>
<thead>
<tr>
<th>Service Description</th>
<th>PPO Allowance</th>
<th>Usual and Reasonable Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammography Screening</td>
<td>same as any other Preventive Service</td>
<td>same as any other Preventive Service</td>
</tr>
<tr>
<td>Coverage of Human Papilloma Virus (HPV) Vaccination</td>
<td>same as any other Preventive Service</td>
<td>same as any other Preventive Service</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Dental Anesthesia</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
<tr>
<td>Diabetes Care Management</td>
<td>The PPO Allowance stated above</td>
<td>The Usual and Reasonable Charge stated above</td>
</tr>
</tbody>
</table>

### AMENDMENT TO DEFINITIONS AMENDMENT

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 aCovered 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.


**Kimberly A. Shaul**
Secretary

**Mark L. Solverud**
President

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191
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 Plans.

*ASK MAYO CLINIC

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.

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. If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 1.877.488.9833 or if you are in a foreign country, call +1.609.452.8570. 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.