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

This health plan satisfies Minimum Creditable Coverage standards and will satisfy the individual mandate that you have health insurance. Please see page 3 for additional information.

IMPORTANT NOTICE
This brochure provides a brief description of the important features of the Policy. It is not a Policy. Terms and conditions of the coverage are set forth in the Policy. We will notify Covered Persons of all material changes to the Policy. Please keep this material with your important papers.

Nondiscriminatory
Health care services and any other benefits to which a Covered Person is entitled are provided on a nondiscriminatory basis, including benefits mandated by state and federal law.
STUDENT PREMIUM

Premium for coverage must be received within the 31-day periods beginning with the start of the first and second semesters.

COST OF COVERAGE – International Student Plan

Annual Premium (12 months) ........................................ $1466

Spring Premium .................................................................$968

EXTENSION OF BENEFITS

The coverage provided under the Policy ceases on the Termination Date. However, if a Covered Person is hospital confined on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues but not to exceed 90 days after the Termination Date.

The total payments made in respect of the Covered Person for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this Extension of Benefits Termination provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

DEFINITIONS

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

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

Covered Injury means a bodily injury that is:

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

Coverage under the School’s policies must have remained continuously in force:

1. From the date of Injury; and
2. Until the date services or supplies are received, for them to be considered a Covered Medical Expense under the Policy. Accident, including related conditions, will be considered one (1) Injury.

Covered Medical Expense means those charges for any treatment, service or supplies that are:

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

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

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which:

1. Causes a loss while the Policy is in force; and
2. Which results in Covered Medical Expenses

Elective Surgery or Elective Treatment means surgery or medical treatment that is:

1. Not necessitated by a pathological or traumatic change in the function or structure of any part of the body; and
2. Which occurs after the Insured Person’s effective date of coverage.

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

Emergency Medical Condition means a medical condition, which:

1. Manifests itself by acute symptoms of sufficient severity (including severe pain); and
2. Causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect

that the absence of immediate medical attention might result in:

a. Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

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

Loss means medical expense caused by Injury or Sickness and covered by the Policy.

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 mean any other licensed practitioner of the healing arts who We are required by law to recognize as a “Physician.” This includes an acupuncturist, a certified nurse-anesthetist, 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 Doctor.

Pre-existing Condition means any health condition, Sickness or Injury;

1. That existed any time prior to the effective date of coverage; and
2. For which medical advice was given or for which a Physician recommended or provided treatment within the six (6) months immediately preceding the Insured Person’s enrollment date under the Policy.

See Pre-existing Condition Limitation on page 18.
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 a:

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

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

You, Your, Yours means the insured student.

**BENEFITS**

Covered Medical Expenses are shown in the Schedule of Benefits.

**ACCIDENT EXPENSE BENEFITS**

When You suffer Loss from Injury, We will pay Covered Medical Expense incurred up to 100% of U&R to the Accident Maximum of $10,000 Per Policy Year then 80% of U&R up to the combined Accident and Sickness Policy year Maximum as stated in the Schedule of Benefits. Covered Medical Expenses are considered incurred on the date the treatment or service is rendered or the supply is furnished. Covered Medical Expense includes: a) treatment by a Doctor; b) hospital confinement; c) services of a registered nurse or licensed practical nurse; d) x-ray service; e) prescription drugs; or f) use of an ambulance. This benefit includes coverage for treatment of Injury to sound natural teeth.

**SICKNESS EXPENSE BENEFITS**

The Policy will pay 100% of U&R, except as specifically stated, for up to $2,000 of Covered Medical Expenses incurred by a Covered Person due to covered Sickness, then 80% up to the combined Accident and Sickness Policy year Maximum as stated in the Schedule of Benefits. Covered Medical Expenses are considered incurred on the date the treatment or service is rendered or the supply is furnished.

**STUDENT HEALTH CENTER REFERRAL**

Where available, the student must first use the resources of the Student Health Center (SHC) where treatment will be administered or referred to. Out Patient Department and Physicians Visit Co-payments will be waived, if You are first seen and referred by the Dean College Health Services or for Preventive/Wellness Expense Benefits. A limited number of Laboratory tests, when ordered by Dean College Health Services will be paid at 100%, subject to the Sickness Maximum. The tests include: Urinalysis/Urine Culture, Rapid Strep Test/ Throat Culture, Thin Prep Pap, DNA Probe, CBC with Diff., Mono Spot, and Beta Sub Pregnancy Test.

**MANDATED BENEFITS**

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

**Autism Spectrum Disorder Benefit:** We will provide coverage for the diagnosis and treatment of Autism Spectrum Disorder on the same basis as any other Covered Sickness. Treatment of Autism Spectrum Disorders includes the following care prescribed, provided or ordered for an Insured Person diagnosed with one of the Autism Spectrum Disorders by a licensed Physician or a licensed psychologist: Habilitative or Rehabilitative Care; Pharmacy Care, Psychiatric Care; Psychological Care and Therapeutic Care. For the purpose of this benefit:

**Autism Spectrum Disorders** means any of the pervasive developmental disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autistic disorder, Asperger's disorder and pervasive developmental disorders not otherwise specified.

**Applied Behavior Analysis** means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

**Diagnosis of Autism Spectrum Disorders** means the medically necessary assessments, evaluations including neuropsychological evaluations, genetic testing or other tests to diagnose whether an individual has one of the autism spectrum disorders.

**Habilitative or Rehabilitative Care** means professional counseling and guidance services and treatment programs, including, but not limited to, Applied Behavior Analysis supervised by a board certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Pharmacy Care means medications prescribed by a licensed Physician and health-related services deemed medically necessary to determine the need or effectiveness of the medications, to the same extent that pharmacy care is provided by the policy or other medical conditions.

**Therapeutic Care** means services provided by licensed or certified speech therapists, occupational therapists, physical therapists or social workers.

**Cancer Treatment Benefits:** We will pay the Usual and Reasonable expenses incurred for treatment of cancer as follows:

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

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

3. **Scalp Hair Prostheses:** We will pay the expenses incurred for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia up to $350 per policy year. Such coverage will be subject to a written prescription from the treating Physician and will be subject to the same limitations and guidelines as any other prosthesis that would be covered by the Policy.

4. **Clinical Trials for Cancer:** We will pay the expenses incurred for Patient Care Services in connection with a qualified cancer clinical trial to the same extent as they would be covered and reimbursed if the Insured Person did not receive care in a Qualified Clinical Trial. Coverage for the services required under this benefit are provided subject to the terms and conditions generally applicable to other benefits provided under the Policy.

5. **Orally Administered Cancer Medications:** We will pay the Usual and Reasonable expense incurred for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on the same basis as
intravenously administered or injected cancer medications that are covered as medical benefits.

For purposes of this benefit:

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

1. An investigational drug or device but a drug or device that has been approved for use in the Qualified Clinical Trial, whether or not the Food and Drug Administration has approved the drug or device for use in treating the Insured Person’s particular condition will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device.
2. Non-health care services that an Insured Person may be required to receive as a result of being enrolled in the clinical trial.
3. Costs associated with managing the research associated with the clinical trial.
4. Costs that would not be covered for non-investigational treatments.
5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the clinical trial.
6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care.
7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but which are being provided at a greater frequency, intensity or duration.
8. Services or costs that are not otherwise covered under the Policy.

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

1. The clinical trial is intended to treat cancer in an Insured Person who has been so diagnosed.
2. The clinical trial has been peer reviewed and is approved by one of the United States National Institutes of Health, a qualified non-governmental research entity identified in guidelines issued by the National Institute of Health for center support grants, the United States Food and Drug Administration pursuant to an investigational new drug exemption, the United States Department of Defense or Veterans Affairs, or with respect to Phase 11, III or IV clinical trials only, a qualified institutional review board.
3. The facility and personnel conducting the trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise.
4. With respect to Phase I clinical trials, the facility will be an academic medical center or an affiliated facility and the clinicians conducting the trial will have staff privileges at said academic medical center.
5. The Insured Person meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
6. The Insured Person has provided informed consent for participation in the clinical trial.
7. The available clinical or pre-clinical data provide a reasonable expectation that the Insured Person’s participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
8. The clinical trial does not unjustifiably duplicate existing studies.
9. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Insured Person.

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

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

The coverage shall include benefits for:

1. Medical, dental, oral and facial surgery;
2. Surgical management and follow-up care by oral and plastic surgeons;
3. Orthodontic treatment and management;
4. Preventative and restorative dentistry to ensure good health;
5. Adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology and nutrition services.

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

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

1. Equipment and supplies for the treatment of diabetes include, but are not limited to the following. We will pay the Usual and Reasonable charges incurred for such supplies.
   a. Lancets and automatic lancting devices
   b. Glucose test strips
   c. Blood glucose monitors
   d. Blood glucose monitors for visually impaired
   e. Control solutions used in blood glucose monitors
   f. Diabetes data management systems for management of blood glucose
   g. Urine testing products for glucose and ketones
   h. Oral anti-diabetic agents used to reduce blood sugar levels
   i. Alcohol swabs
   j. Syringes
   k. Injection aids including insulin drawing up devices for the visually impaired
   l. Cartridges for the visually impaired
   m. Disposable insulin cartridges and pen cartridges
   n. Insulin pumps and equipment for use of the pump including batteries
   o. Insulin infusion devices
   p. Oral agents for treating hypoglycemia such as glucose tablets and gels
   q. Glucagon for injection to increase blood glucose concentration
2. We will pay the Usual and Reasonable charges for the following:
   a. Insulin and prescribed oral diabetes medications that influence blood sugar levels, on the same basis as other Prescription Drugs;
   b. Laboratory tests, including glycosylated hemoglobin, or HbA1c tests; and
   c. Therapeutic molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating Physician and prescribed by a podiatrist or other qualified Physician and furnished by a podiatrist, orthotist, prosthetist or pedorthist.

3. We will also pay Reasonable and Customary charges for diabetes outpatient self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including medical nutrition therapy when provided by a certified diabetes health care provider. This benefit will be limited to visits where a Physician diagnoses a significant change in the Insured Person's symptoms or conditions that necessitate changes in an Insured Person's self-management or where reeducation or refresher education is necessary.

Coverage also includes home visits. Such education may be provided by certified diabetes health care provider, which means:
   a. A licensed health care professional with expertise in diabetes;
   b. A registered dietician; or
   c. A health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

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

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

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

When prescription drugs are prescribed as part of the infertility treatment, We will pay the Usual and Reasonable expenses incurred on the same basis as for any other prescription drugs.

We will not cover the following as part of an infertility treatment program:
   1. Any experimental infertility procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner;
   2. Surrogacy;
   3. Reversal of voluntary sterilization; and
   4. Cryopreservation of eggs.

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

**Mental Illness Benefit:** We will pay the Usual and Reasonable expenses incurred for the diagnosis and treatment of the following Biologically-Based Mental Disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM:
   1. schizophrenia;
   2. schizoaffective disorder;
   3. major depressive disorder;
   4. bipolar disorder;
   5. paranoia and other psychotic disorders;
   6. obsessive-compulsive disorder;
   7. panic disorder;
   8. delirium and dementia;
   9. affective disorders;
   10. eating disorders;
   11. post-traumatic stress disorder; and
   12. Substance abuse disorders.

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

We will also pay the Usual and Reasonable expenses for covered children and adolescents under the age of 19 for the diagnosis and treatment of non-Biologically-Based Mental Disorders or other behavioral or emotional disorders which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent. Such interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to:
   1. an inability to attend school as a result of such a disorder;
   2. the need to hospitalize the child or adolescent as a result of such a disorder; or
   3. a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

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

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

For purposes of this section, Confinement will mean that the Insured Person must be confined in an either:
1. A general Hospital licensed to provide such services;
2. A facility under the direction and supervision of the Department of Mental Health;
3. A private mental Hospital licensed by the Department of Mental Health; or
4. A substance abuse facility licensed by the Department of Public Health.

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

For the purposes of this Benefit, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be on the same basis as any other Covered Sickness.

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

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

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

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

We will also provide coverage for the expenses incurred in the purchase of a hearing aid for an Insured Person 21 years of age or younger when prescribed or recommended by a licensed Physician. We pay the full cost of one (1) hearing aid per hearing impaired ear, up to two thousand dollars ($2,000) for each hearing aid every 36 months. Benefits include fitting, adjustments and supplies, including ear molds. An Insured Person may choose a hearing aid that is priced higher than the benefit payable under this benefit and pay the difference between the hearing aid and the benefit payable.

LIMITATIONS AND EXCLUSIONS

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act. The plan does not cover 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. Any expenses in excess of Usual and Reasonable charges.
2. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
3. 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.
4. Services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental injury.
5. An Insured person’s: Committing or attempting to commit a felony, being engaged in an illegal occupation, or participation in a riot.
6. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
7. 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.
8. 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.
9. 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.
10. Expenses covered under any Workers Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
11. 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.

12. Conditions due to accidental bodily injury occurring prior to the Insured Person's effective date of coverage.

13. Preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.

14. Treatment to the teeth, including surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. This exclusion does not apply to the repair of injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.

15. Loss resulting from playing, practicing, traveling to or from or participating in, or conditioning for, any Intercollegiate sports in excess of $10,000 per accident.

16. Services or supplies not related to the medical care of the Insured Person’s Injury or Sickness.

17. Expense incurred after: the date insurance terminates as to the Insured Person and the end of the Benefit Period specified in the Benefit Schedule.

**PRE-EXISTING CONDITIONS LIMITATION**
(Not applicable to any Covered Person under the age of 19.)

The Policy does not cover Pre-existing Conditions for the first six (6) months following the enrollment date of an Insured Person for coverage under the Policy. However, We will waive this Limitation for an Insured Person who:

1. Has been Continuously Insured for at least twelve (12) consecutive months under one or more student insurance policies issued to the Policyholder; or
2. Can provide satisfactory evidence of prior Creditable Coverage. To qualify for this waiver, an Insured must fulfill all of the following requirements:
   a. He or she must not be covered under any other health insurance;
   b. He or she must have had health insurance for a total of 18 months, with no break in coverage longer than 63 days; and
   c. His or her most recent coverage must meet the definition of Creditable Coverage in the Policy.

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

**TERMINATION OF COVERAGE**
Your coverage will terminate on the earlier to occur of these dates:
1. The date the Policy terminates for all insured persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date an Insured Person ceases to be eligible for the insurance; or
4. The date an Insured Person enters military service.

Premium refund will be made only in the event of the insured student entering the armed services.

**CLAIM PROCEDURE**

In the event of Covered Accident or Sickness
1. Contact Your Student Health Services, if available. If Student Health Services is not available, report to the nearest Doctor of Hospital and follow the prescribed treatment advice.
2. Itemized billings (Written Proof of Loss) should be submitted by Your health care provider or You within 90 days of treatment, or as soon as reasonably possible.

All Claims should be submitted to the Claims Administrator shown below:

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540
Toll Free (800) 633-7867
www.chpstudent.com

Within 45 days following receipt of the appropriate documentation, we will either: 1) make payment for the services provided, 2) notify the provider or claimant in writing of the reason or reasons for nonpayment, or 3) notify the provider or claimant in writing of what additional information or documentation is necessary to complete the claim filing. If we fail to comply, We are required to pay, in addition to any reimbursement for health care services provided, interest on the benefits beginning 45 days after receipt of the properly documented claim at the rate of 1.5 percent (1.5%) per month, not to exceed 18 percent (18%) per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

There is no utilization review performed on the policy.

**HOW TO FILE AN APPEAL**

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 must request an appeal in writing within 180 days of the date appearing on the EOB. The appeal request must include why they disagree with the way the claim was processed. The request must include any additional information they feel supports their request for appeal, such as medical bills confirming service was received for a covered benefit. Information should be provided to:

National Guardian Life Insurance Company
C/o Consolidated Health Plans, Inc.
2077 Roosevelt Avenue
Springfield, MA 01104

We will resolve the grievance within thirty (30) calendar days of receiving it. If We are unable to resolve the grievance within that period, the time period may be extended thirty (30) calendar days if We notify in writing the person who filed the grievance. The notice will include advice as to when resolution of the grievance can be expected and the reason why additional time is needed.

**CONFORMITY WITH STATE STATUTES**

Any provision of the Policy which, on its effective date, is in conflict with the statutes of the state in which the Policy was delivered or issued, is hereby amended to conform to the minimum requirements of such statutes.

Questions? Need More Information?
For general information on benefits, on how to enroll, or service issues, please contact:
Consolidated Health Plans
For information on submitting claims or to check the status of a claim, please contact the **Claims Administrator:**

**Consolidated Health Plans**
2077 Roosevelt Avenue  
Springfield, MA 01104  
(413) 733-4540 or Toll Free (800) 633-7867  
www.chpstudent.com

**Group Number:** S205999

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

For a copy of the Company’s privacy notice you may go to:  
www.consolidatedhealthplan.com/about/hipaa  
or

Request one from the Health Office at your School  
or

Request one from:  
Commercial Travelers Mutual Insurance Company  
C/O Privacy Officer  
70 Genesee Street  
Utica, NY 13502

*(Please indicate the school you attend with your written request)*

The Plan is Underwritten By:  
**National Guardian Life Insurance Company**  
Policy Form: NBH-280(2013)MA  

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

**Representations of this plan must be approved by the Company**

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