Student Health Insurance Program

Designed for the Students of

The New England Institute of Art®

2014-2015

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Underwritten By:
National Guardian Life Insurance Company
Policy Number: 2014I5A16

Effective July 1, 2014 to June 30, 2015
Group Number: S206700

IMPORTANT NOTICE

This brochure/certificate 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. Please keep this material with Your important papers.

This health plan satisfies **Minimum Creditable Coverage standards** and **satisfies** the individual mandate that you have health insurance. Please see page 2 for additional information.

14-I5A16(cert.)

ELIGIBILITY AND ENROLLMENT

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE

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

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

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

To be eligible for coverage under this Policy, a Student must:

1. be enrolled as a full-time student or carrying a course load equivalent to at least 3/4 full-time; and
2. pay the required premium; and
3. attend classes for at least the first thirty-one (31) days of the period for which premium has been paid except in the case of medical withdrawal.

If You are eligible to be covered under this Program, You are automatically enrolled unless You can certify that You have comparable coverage.

You may enroll in this Insurance Program only during the thirty-one (31) day periods beginning with the start of the period when You are first eligible for enrollment. If You are eligible for coverage and wish to enroll in the Program after these enrollment opportunities, You must present documentation from Your former insurance company that it is no longer providing You with personal accident and health insurance coverage. Your effective date under this Program will be the date Your former insurance expired, if You make the request for coverage within thirty-one (31) days after it expires. Otherwise, the effective date will be the first of the month following Your request. Your premium for this coverage must accompany the request.

STUDENT PREMIUMS

Premium for coverage must be received within the thirty-one (31) day periods beginning with the start of the enrollment period.

Annual	Fall	Winter	Spring
7/1/14-6/30/15	10/1/14-6/30/15	1/1/15-6/30/15	4/1/15-6/30/15
$1,225	$916	$613	$307

An Administrative Fee is included in the rates above

REFUND OF PREMIUM

Premiums received by Us are fully earned upon receipt. Refund of premium will be considered only:

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

No other refunds will be allowed.

DEFINITIONS

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.

Co-payment means the cost an Insured Person pays as a fixed dollar amount for a covered service This amount represents the amount of Usual and Reasonable expenses for treatment that We do not pay, which are listed on the Schedule of Benefits. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.

Covered Injury means a bodily injury that is:

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

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

1. From the date of Injury; and
2. Until the date services or supplies are received, for them to be considered as a Covered Medical Expense under the Policy.

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

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

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

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

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

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
4. 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.

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. 10. Pediatric services, including oral and vision care.

Insured Student 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 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. Physician also includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adheres to the rules and

regulations of the First Church of Christ, Scientist, Boston, Massachusetts.

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

The Policy will pay 80%, except as specifically stated, of Covered Medical Expenses incurred by a Covered Person due to covered Sickness or covered Injury.Covered Medical Expenses are considered incurred on the date the treatment or service is rendered or the supply is furnished.

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

If, as the result of a covered Accident, an Insured Person sustains any of the following losses within ninety (90) days of a covered Accident we will pay the benefit shown:

FOR LOSS OF:	AMOUNT
Loss of Life	$10,000
Loss of Hand	$5,000
Loss of Foot	$5,000
Loss of either one hand one foot or sight of one eye	$5,000
Loss of more than one of the above losses due to one Accident	$10,000

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The principal sum is the largest amount payable under this benefit for all losses resulting from any one (1) Accident.

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.

Mandate Disclaimer: If any Preventive Services Benefit is subject to the mandated benefits required by state law, they will be administered under the federal or state guideline, whichever is more favorable to the student.

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 $500 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.
6. **Radiation Therapy and Chemotherapy** – We will pay the Usual and Reasonable expenses incurred for prescribed x-ray therapy and chemotherapy. This coverage includes:
   - Radiation therapy using isotopes, radium, radon, or other ionizing radiation.
   - X-ray therapy for cancer or when it is used in place of surgery.

   - Drug therapy for cancer (chemotherapy).

For purposes of this benefit:

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

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

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

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

3. The facility and personnel conducting the trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise.
4. With respect to Phase I clinical trials, the facility will be an academic medical center or an affiliated facility and the clinicians conducting the trial will have staff privileges at said academic medical center.
5. The Insured Person meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial.
6. The Insured Person has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards.
7. The available clinical or pre-clinical data provide a reasonable expectation that the Insured Person's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial.
8. The clinical trial does not unjustifiably duplicate existing studies.
9. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Insured Person.

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

Chiropractic Care Benefit: We cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any necessary laboratory tests will be covered in accordance with the terms and conditions of the Policy.

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.

Cytologic Screening (pap smear) and Mammographic Examination: We will pay the Usual and Reasonable expenses incurred for cytologic screening and mammographic examination. In the case of benefits for cytologic screening, benefits shall provide for an annual cytologic screening for women eighteen years of age and older; and in the case of benefits for mammographic examination benefits shall provide for a baseline mammogram for women between the ages of thirty-five and forty and for a mammogram on an annual basis for women forty years of age and older. If benefits are also provided under the Preventive Services Benefit, We will pay only under one benefit. That will be the greater of the two benefits.

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 lancing devices
   b. Glucose test strips
   c. Blood glucose monitors
   d. Blood glucose monitors for visually impaired
   e. Control solutions used in blood glucose monitors;

   f. Diabetes data management systems for management of blood glucose
   g. Urine testing products for glucose and ketones
   h. Oral anti-diabetic agents used to reduce blood sugar levels
   i. Alcohol swabs
   j. Syringes
   k. Injection aids including insulin drawing up devices for the visually impaired
   l. Cartridges for the visually impaired
   m. Disposable insulin cartridges and pen cartridges
   n. Insulin pumps and equipment for the use of the pump including batteries
   o. Insulin infusion devices
   p. Oral agents for treating hypoglycemia such as glucose tablets and gels
   q. Glucagon for injection to increase blood glucose concentration
   r. Visual magnifying aids for use by the legally blind
   s. Voice synthesizers for blood glucose monitors for use by the legally blind
   t. Other diabetes equipment and related supplies to the treatment of diabetes
2. We will pay the Usual and Reasonable charges for the following:
   a. Insulin and prescribed oral diabetes medications that influence blood sugar levels, on the same basis as other Prescription Drugs;
   b. Laboratory tests, including glycosylated hemoglobin, or HbAlc, tests; an
   c. Therapeutic molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating Physician and prescribed by a podiatrist or other 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.

Early Intervention Services - We will pay the Usual and Reasonable expenses incurred for the following treatment:

1. The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth. Such coverage shall also include those special medical formulas which are approved by the commissioner of the Department of Public Health, prescribed by a Physician, and are provided for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or to protect the unborn fetuses of pregnant women with phenylketonuria. Such coverage will also include screening for lead poisoning as required by the commonwealth of Massachusetts.
2. Preventive and primary care services for children. For the purposes of this paragraph Preventive Care Services means services rendered to a dependent child of an Insured from the date of birth through the attainment of six years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six times during the child's first year after birth, three times during the next year, annually until age six. Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician.
3. Early intervention services delivered by certified early intervention specialists, as defined in the early intervention operational standards by the Department of Public Health and in accordance with applicable certification requirements. Such services shall be provided by early intervention specialists who are working in early intervention programs certified by the Department of Public Health, for children from birth until their third birthday. [Reimbursement of costs for such services shall be part of a basic benefits package offered by Us or a third party, with a maximum benefit of $5,200 per year per child.
4. Coverage for the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the Department of Public Health.

If the expense is also covered under the Preventive Services Benefit, We will pay only under one benefit. That will be the greater of the two benefits.

Fitness Benefit – We will reimburse an Insured Student up to a fixed amount in each Policy Year for each membership fee paid to a health club membership or for fitness classes at a health club. The total fitness benefit for a Policy Year is $150, which can represent any combination of fitness fees incurred during the calendar year. The fitness benefit applies to fees paid for: privately-owned or privately-sponsored health clubs or fitness facilities, including individual health clubs and fitness centers; YMCAs; YWCAs; Jewish Community Centers; and municipal fitness centers. No fitness benefit is provided for any fees or costs that pay for: country clubs; social clubs (such as ski or hiking clubs); sports teams or leagues; spas; instructional dance studios; and martial arts schools.

Hormone Replacement Therapy Services; Outpatient Contraceptive Services: We will pay the Usual and Reasonable expenses incurred for hormone replacement therapy services for peri- and post-menopausal women and Outpatient Contraceptive Services under the same terms and conditions as for such other outpatient services.

Outpatient Contraceptive Services: means consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of all contraceptive methods to prevent pregnancy that have been approved by the United States Food and Drug Administration.

We will provide benefits for hormone replacement therapy for peri and post menopausal women and for outpatient prescription contraceptive drugs or devices which have been approved by the United States Food and Drug Administration under the same terms and conditions as for such other prescription drugs or devices, provided that in covering all FDA approved prescription contraceptive methods, nothing in this benefit precludes the use of closed or restricted formulary.

Human Leukocyte Testing: We will pay the Usual and Reasonable expenses incurred for the cost of human leukocyte antigen testing or histo compatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. The coverage 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 Commonwealth of Massachusetts.

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)

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:

Mental Illness benefits will be paid on the same basis as any other sickness.

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 benefits for the diagnosis and treatment of all other mental disorders not otherwise defined as Biologically-Based Mental Disorders. 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.
5. 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.

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.

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 Chrohn'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.

Organ Transplant Benefit: We will pay the Usual and Reasonable expenses incurred for the cost of human organ (or tissue) transplants. This coverage includes: the Harvesting of the donor's organ (or tissue) when the recipient is an Insured Person, and drug therapy that is furnished during the transplant procedure to prevent the transplanted organ (or tissue) from being rejected.

Harvesting means the surgical removal of the donor's organ (or tissue) and the related services and/or tests that are required to perform the transplant itself. This coverage does not include the Harvesting of the donor's organ (or tissue) when the recipient is not an Insured Person.

Oxygen and Respiratory Therapy: We will pay the Usual and Reasonable expenses for oxygen and the equipment to administer it for use in the home. These items must be obtained from an oxygen supplier. This includes oxygen concentrators. Respiratory therapy services include, but are not limited to, postural drainage and chest percussion.

Pediatric Dental Care Benefit: We will pay the Usual and Reasonable expenses incurred for Routine Dental Care for Insured Students and Dependent Children up to age 19. Orthodontia is excluded (other than medically necessary orthodontia).

As used in this Benefit:

Routine Dental Care means dental care provided in the office of a dentist, including:

- One complete initial oral exam by the dentist;
- One periodic oral exam every six (6) months;
- One cleaning every six (6) months;
- One fluoride treatment every six (6) months; and
- Bitewing x-rays once every six (6) months.

Pediatric Vision Care Benefit: We will pay the Usual and Reasonable expenses incurred for one Visual Examination every (24) twenty-four months for Insured Students and Dependent Children up to age 19.

As used in this Benefit:

Vision Examination means examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will cover one vision examination in any twenty-four (24) month period, unless more frequent examinations are necessary as evidenced by appropriate documentation. The vision examination must be performed by an ophthalmologist or by an optometrist.

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. We will pay the Usual and Reasonable expenses incurred for scalp hair prosthesis (wigs) only when hair loss is due to: Chemotherapy; radiation therapy; infections; burns; traumatic injury; congenital baldness; and medical conditions resulting in alopecia areata or alopecia totalis (capitus). Scalp hair prosthesis has a benefit limit of $500 per Policy Year which applies to the Policy Year regardless of whether benefit is paid under this benefit or the Cancer Treatment Benefit. No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

For purposes of this benefit:

Prosthetic Device means an artificial limb device to replace, in whole or in part, an arm or leg.

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

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

Weight Loss Program Benefit: We will reimburse an Insured Person up to a fixed amount in each Policy Year for membership fees paid to a hospital-based weight loss program or for non-hospital-based weight loss programs sponsored by the School. The total weight loss program benefit for the Policy Year is $150, which can represent any combination of weight loss program fees incurred during the Policy Year. The weight loss program benefit is available to the Insured Student and any other enrolled Insured Persons.

LIMITATIONS AND EXCLUSIONS

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of that Act. The policy does not cover Loss nor provide benefits for:

1. Any expense 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. Services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental Injury or as specifically provided in the Schedule of Benefits.
4. An Insured person's: Committing or attempting to commit a felony, being engaged in an illegal occupation, or participation in a riot.
5. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Policy.
6. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within twenty-four (24) hours of the Accident or results from Reconstructive Surgery. For the purposes of this provision, Reconstructive Surgery means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to

either improve function or to create a normal appearance, to the extent possible. For the purposes of this provision, Plastic or Cosmetic Surgery means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

7. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
8. Sky diving, ultra light aircraft, parasailing, sail planing, hang gliding, bungee jumping, or other hazardous sport or hobby.
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. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
11. Expenses covered under any Workers Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
12. Treatment to the teeth, including surgical extractions of teeth, except as specifically provided in the Schedule of Benefits. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
13. Expenses payable under any prior Policy which was in force for the person making the claim.
14. Expense incurred after the date insurance terminates as to the Insured Person and the end of the Benefit Period specified in the Benefit Schedule.
15. Preventative medicines, serums, or vaccines of any kind, except as specifically provided under the Policy, or considered a Preventive Service.
16. International Students Only - Expenses incurred within the Insured Person's Home Country or country of regular domicile.
17. Services or supplies not related to the medical care of the Insured Person's Injury or Sickness.
18. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sports.

19. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
20. Expenses for weight increase or reduction, unless otherwise specifically covered under the Policy.
21. Expenses for hair growth or removal, unless otherwise specifically covered under the Policy.
22. Elective abortion.
23. Private Duty Nursing, except as specifically provided on the Schedule of Benefits.
24. Custodial Care, services and supplies.

COORDINATION OF BENEFITS

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

TERMINATIONS

Your coverage will terminate on the earlier to occur of these dates:

1. The date the Policy terminates for all insured persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date an Insured Person ceases to be eligible for the insurance; or
4. The date an Insured Person enters military service.

EXTENSION OF BENEFITS

Coverage under this Policy ceases on the Termination Date. However, coverage for an Insured Person will be extended as follows: If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to ninety (90) days from the Termination Date while such confinement continues.

CLAIM PROCEDURES

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

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104

within thirty (30) days from the date of injury or first treatment for Sickness. Medical bills must be submitted within ninety (90) days from the date of treatment. We will pay benefits to

you or a parent when a receipted bill is submitted for a covered claim. When benefits are assigned, they will be paid directly to the provider of hospital-medical care. Claim forms may be obtained from the college, if at college, or from the above when away from college.

Within forty-five (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 forty-five (45) days after receipt of the properly documented claim at the rate of 1.5 percent (1.5%) per month, not to exceed eighteen percent (18%) per year. These provisions do not apply to claims that a carrier is investigating because of suspected fraud.

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 another 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 statues.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 733-4540
Toll Free (800) 633-7867
www.chpstudent.com
Group Number: S206700

This plan is underwritten by:
National Guardian Life Insurance Company
As Policy Form Number: NBH-280(2014)-MA.

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

For a copy of the Company's privacy notice you may:
go to
www.consolidatedhealthplan.com/about/hipaa
or
Request one from the Health Office at your School
Or
Request one from:
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)

Servicing Broker:
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Local: (617) 472-5324
Out of area: (800) 437-6448
www.universityhealthplans.com
Please visit our website for frequently asked questions and answers regarding this plan, or email us at info@univhealthplans.com

Representations of this plan must be approved by the Company

VALUE ADDED SERVICES

The following services are not part of the Plan Underwritten by Companion Life Insurance Company. These value added options are provided by Consolidated Health Plans in partnership with Davis Vision and FrontierMEDEX.

VISION DISCOUNT PROGRAM

A Vision Discount Program is available to students enrolled in the New England Institute of Art Student Health Insurance Plan. Students will be responsible for paying for services up front but will receive a discount off retail prices. For more information please go to: www.chpstudent.com.

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

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

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

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

New England Institute of Art 2014-2015 Schedule of Benefits	
Deductible	$0 per Policy Year
Benefit Period	Policy Year
Medical Maximum	Unlimited
Out of Pocket Maximum	$6,350 per Person
Coinsurance	80% of Usual & Reasonable
Inpatient Benefits	**Amount Payable**
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.	Per Coinsurance Stated Above
Intensive Care, including 24-hour nursing care.	Per Coinsurance Stated Above
Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Services include, but are not limited to cost for use of an operating room; prescribed medicines; laboratory tests; therapeutic services; x-ray examinations; casts and temporary surgical appliances; oxygen, oxygen tent; blood and blood plasma; and miscellaneous supplies.	Per Coinsurance Stated Above
Preadmission Testing, routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital.	Per Coinsurance Stated Above
Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services, for inpatient surgery (including pre- and post-operative visits). If two (2) or more surgical procedures are performed through the same incision or in immediate succession at the same session, benefits will equal the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician's visits.	Per Coinsurance Stated Above
Physical Therapy, when prescribed by the attending Physician.	Per Coinsurance Stated Above
Physician's Visits, not to exceed one (1) visit per day. Surgeon's fees are not payable under this benefit.	Per Coinsurance Stated Above
Outpatient Benefits	**Amount Payable**
Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services, for outpatient surgery (including fees for pre- and post-operative visits). If two (2) or more surgical procedures are performed through the same incision or in immediate succession at the same session, benefits will equal the benefit payable for the procedure with highest benefit value.	Per Coinsurance Stated Above
Outpatient Surgery Miscellaneous, (excluding non-scheduled surgery) for surgery performed in a hospital emergency room, trauma center, physician's office, outpatient surgical center or clinic. Services include operating room; therapeutic services; oxygen, oxygen tent; blood and blood plasma; and miscellaneous supplies.	Per Coinsurance Stated Above
Outpatient Facility Fee	Per Coinsurance Stated Above
Short Term Rehabilitation Therapy (Physical Therapy , Speech Therapy, and Occupational Therapy)	100% of U&R after a $10 co-pay per office visit Per Coinsurance Stated Above for other services and supplies
Primary Care Visit to treat an Injury or Sickness (includes syringes and needles dispensed during a visit), **Specialist Visit, Other Practitioner Office Visit, Consultant Physician Services** when requested by the attending physician and **Urgent Care Visits.**	100% of U&R after a $10 co-pay per visit
Imaging Tests, Diagnostic X-Ray Services and Laboratory Procedures, when prescribed by a Physician	Per Coinsurance Stated Above
Skilled Nursing Facility Benefit (subject to 100 days per Policy Year)	Per Coinsurance Stated Above
Podiatry Care Benefit	Same as any other covered condition
TMJ Disorder Treatment	Same as any other covered condition
Dialysis Services Benefit	Same as any other covered condition
Emergency Services, in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, surgical center or clinic.	Per Coinsurance Stated Above, after $100 co-pay per visit. Co-pay waived if admitted.
Diagnostic X-ray Services, when prescribed by a physician.	Per Coinsurance Stated Above
Laboratory Procedures (Outpatient), when prescribed by a Physician.	Per Coinsurance Stated Above
Prescription Drugs (Rx Card), medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made. Benefits include hypodermic needles or syringes required for the administration of a prescription drug. Prescriptions must be filled at an Express Scripts Participating Pharmacy www.express-scripts.com. Co-pays do not apply to generic prescription contraceptives.	100%, after $5 co-pay for generic drugs or $10 co-pay for brand name drugs
Outpatient Miscellaneous Expenses (Excluding surgery), including other reasonable expenses for services and supplies that have been prescribed by the attending Physician.	Per Coinsurance Stated Above
Hospice Care Coverage, when diagnosed with a terminal illness by a licensed Physician. Medical prognosis must be death within six (6) months.	Per Coinsurance Stated Above
Home Health Care Expense, when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary.	Per Coinsurance Stated Above, after $50 deductible per Policy Year; up to 40 visits per Policy Year
Other Benefits	**Amount Payable**
Mental Illness Benefit	Same as any other covered condition
Sickness Dental Expense, for impacted wisdom teeth.	Per Coinsurance Stated Above
Accidental Injury Dental Treatment	Per Coinsurance Stated Above
Ambulance Service, for transportation to or from a Hospital by ground ambulance.	Per Coinsurance Stated Above
Durable Medical Equipment, Braces and Appliances	Per Coinsurance Stated Above
Maternity Benefit, including hospital stays, inpatient Physician or surgeon charges and Physician-directed follow-up care.	Same as any other covered condition
Routine Newborn Care, during the first thirty-one (31) days immediately following the birth.	Same as any other covered condition
Preventative Services, co-pays and coinsurance do not apply.	100% of Usual & Reasonable
Accidental Death and Dismemberment	Principal Sum: $10,000
Medical Treatment Received in Home Country (International Students Only)	Not covered