Student Health Insurance Plan

Plan Year 17/18

*Designed Exclusively for the Students of:*

Bryant University
Smithfield, RI
2017 - 2018

*Underwritten by:*
National Guardian Life Insurance Company
Madison, WI

Policy Number: 2017I5A67
Group Number: ST0818SH
Effective: 8/15/2017 - 8/15/2018

*Administered by:*
Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA

ST0818SH-1718(Bro.)
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Dear Student:

Bryant University provides access to a Student Health Insurance Plan. At the beginning of each year you are given the opportunity to enroll in this student insurance plan. When making your insurance decision, check your current coverage carefully as frequently students arrive on campus without adequate coverage, especially if covered by a Health Maintenance Organization (HMO) or a managed care plan that has limited or no benefits in the Smithfield, RI area. Make sure you are fully covered while on campus and throughout the policy year for inpatient and outpatient hospitalization, diagnostic testing and x-ray services, prescription drugs, and mental health services. Also be aware of any deductibles required by your current plan.

STUDENT HEALTH INSURANCE PLAN

This is a brief description of the Student Health Insurance Plan available for the students of Bryant University. National Guardian Life Insurance Company underwrites this Plan. The exact provisions governing this insurance are contained in the Master Policy issued to the University and may be viewed at the University during business hours. The Master Policy shall control in the event of any conflict between this Brochure and the Policy.

ELIGIBILITY

All full-time students at Bryant University are eligible to enroll in this Insurance Plan. All International Students will be automatically enrolled in the health insurance but have the option to waive the insurance if they have proof of comparable coverage. Students must actively attend classes for at least the first thirty-one (31) days after the date for which coverage is purchased.

The Company maintains its right to investigate student status and attendance records to verify that the policy eligibility requirements have been met. If and whenever the Company discovers that the policy eligibility requirements have not been met, its only obligation is refund of premium. All International Students will be automatically enrolled in the health insurance but have the option to waive the insurance if they have proof of comparable coverage.

ONLINE WAIVER PROCESS

The online Waiver process is the only accepted process for making your insurance selection. The deadline for processing the online waiver is **August 1, 2017** for students enrolling in the fall term and **February 1, 2018** for students newly enrolling in the spring term. Students who waive the Student Health Insurance Plan in the fall, waive coverage for the entire policy year. To document proof of comparable coverage, students need to complete the online waiver and submit it by the deadline date. To complete the online waiver, log on to the Bryant portal at [https://my.bryant.edu](https://my.bryant.edu), click on the Banner icon, choose Student Services and Financial Aid, then Health and Medical Forms and complete the “Health Insurance Information” form. If you waive the school health plan, you must provide Health Services with proof of your own health insurance by submitting a copy of the front and back of your insurance card.

INTERNATIONAL STUDENT WAIVER PROCESS

All International Students will automatically be enrolled and billed $2,392 for the Student Health Insurance Plan unless they waive the insurance plan and also provide proof of comparable coverage in another health insurance plan (preferably in the United States that will be in effect from August, 2017 through August, 2018). If you have your own health insurance, you must provide proof of the alternative insurance to Health Services by August 1, 2017 by logging into [https://my.bryant.edu](https://my.bryant.edu), click on the Medicat icon, then Required Forms, and then finally Insurance Entry. Please input your insurance information and click on the Insurance Waiver link to waive the student health insurance. Once you complete the health insurance information and submit it online, the charge will be removed from your Bryant student account if the alternative insurance is acceptable. If you are waiving the plan, please provide a copy of the front and back of your insurance card to Health Services as proof of health insurance. Bryant University reserves the right to audit and subsequently reject a waiver request. If it is determined that a student waived coverage with a health insurance plan that was not comparable coverage, the student will be automatically enrolled in the Student Health Insurance Plan, effective the date that the determination was made and there will be no pro-rata refund of premium.
**QUALIFYING EVENT ENROLLMENT**

In the event a student waives the Student Health Insurance Plan and then loses coverage due to a qualifying event, (i.e. parent loss of coverage or the maximum age limit available is attained), students have the right to petition to add coverage within thirty-one (31) days of the qualifying event. If the petition is received within thirty-one (31) days of the qualifying event, there will be no break in coverage. Petitions received after the thirty-one (31) days, the effective date of coverage will be the date that the petition is received by University Health Plans. If approved, the premium will not be prorated.

**DEPENDENT ELIGIBILITY**

Students enrolled in the Student Health Insurance Plan may enroll their eligible Dependents (as defined) at an additional cost.

“Dependent” means: 1) An Insured Student’s lawful spouse or lawful Domestic Partner; 2) An Insured Student’s dependent biological or adopted child or stepchild under age 26; and 3) An Insured Student’s unmarried biological or adopted child or stepchild who has reached age 26 and who is: a. Primarily dependent upon the Insured Student for support and maintenance; and b. Incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap. Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

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

**DEPENDENT ENROLLMENT**

There are two ways to submit dependent enrollment information. You may request a Dependent Enrollment form by contacting University Health Plans at 800-437-6448, or you may submit an Online Dependent Enrollment Form. To submit dependent information online, go to www.universityhealthplans.com.

Payment for dependent coverage is in addition to the fee for student coverage. New or previously insured Dependents must be enrolled by September 15, 2017 for annual coverage or February 25, 2018 for spring semester for new students to Bryant University. If the deadline for enrolling an eligible dependent is not met, the dependent cannot be added until the following school term. The deadline to add eligible dependents due to a qualifying event (i.e. birth, marriage, loss of coverage), is thirty-one (31) days from the qualifying event in order to avoid a break in continuous coverage. If the deadline is not met, the effective date will be the postmark date on the envelope or the date the online Dependent Enrollment form is submitted.

**EFFECTIVE AND TERMINATION DATES**

**Effective Dates:** Insurance under the Policy will become effective on the later of:

1. The Policy effective date;
2. The start date of the term for which premium has been paid;
3. The day after the Enrollment Form (if applicable) and premium payment is received by the Company, its authorized agent or the School;
4. The day after the date of postmark if the Enrollment Form is mailed;
5. For International Students or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be no more than 48 hours later than the departure from the Home Country.

Dependent’s coverage, under the Voluntary Participation Basis, becomes effective on the later of:

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

The last date for enrollment is shown in the Insurance Information Schedule. The Enrollment Period will run from the start of the quarter or semester for which coverage is desired.
**Termination Dates:** An Insured Person’s insurance will terminate on the earliest of:

1. The date 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; or
5. For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks);
6. For International Students, the date the student ceases to meet Visa requirements;
7. On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an unplanned error.

The Policy is renewed as a new policy for the term August 15, 2017 to August 15, 2018 as Policy Number 2017I5A67. All time periods begin and end at 12:01 A.M., local time, at the Policyholder’s address.

<table>
<thead>
<tr>
<th>PLAN COSTS</th>
<th>Annual* 8/15/17-8/15/18</th>
<th>Spring Term* 1/15/18-8/15/18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$2,392</td>
<td>$1,390</td>
</tr>
<tr>
<td>1 Dependent</td>
<td>$2,392</td>
<td>$1,390</td>
</tr>
<tr>
<td>2 Dependents</td>
<td>$4,784</td>
<td>$2,780</td>
</tr>
<tr>
<td>3 or more Dependents</td>
<td>$7,176</td>
<td>$4,170</td>
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</tbody>
</table>

Dependent rates are in addition to the student rate

*The above rates include an administrative fee.

**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 minus the cost of any benefits paid by Us will be made. Coverage for Insured students who withdraw for any reason after the first 31 days will continue through the end of the Policy Term. No refund will be made available.

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 or her entry into the service. A pro rata refund of premium will be made for such person upon written request received by Us within ninety (90) days of withdrawal from school.

3. For International Students, Scholars, Visiting Faculty member and/or their covered Dependents. We will refund a pro rata portion of the premium actually paid for any individual who:
   a. Withdraws from School during his/her first semester; and
   b. Returns to his/her Home Country.

   A written request must be sent to us within 60 days of such departure

No other refunds will be allowed.

**PREFERRED PROVIDER NETWORK**

The Bryant University Student Health Insurance Plan provides access to hospitals and health care providers, who participate in Preferred Provider Networks, both locally and across the country. The advantage to using Preferred Providers is that these providers have agreed to accept a predetermined fee or PPO Allowance as payment in full for their services. Consequently, when Insured Persons use Preferred Providers, out-of-pocket expenses may be less because any applicable coinsurance will be based on a PPO Allowance.

The Insured Person should be aware that Preferred Provider Hospitals might be staffed with Out of Network Providers. As a result, receiving services or care from an Out of Network Provider at a Preferred Provider Hospital does not guarantee that all charges will be paid at the Preferred Provider level of benefits. The participation of specific providers in the Preferred Provider Networks is subject to change without notice. Insured Persons should always confirm when making an appointment that the provider participates in a Preferred Provider Network.

**First Health Network** is the Preferred Provider Network and provides access to providers located across the United States. To determine if a provider participates in First Health, students can visit [www.firsthealth.com](http://www.firsthealth.com). It is important that Insured Persons verify that their providers are Preferred Providers each time they call for an appointment or at the time of service.

Preferred Providers are the Physicians, Hospitals and other health care providers who have contracted to provide specific medical care at negotiated prices.
PPO Allowance is the amount a Preferred Provider will accept as payment in full for covered medical expenses. Out of Network refers to a provider who has not agreed to any prearranged fee schedules. We will not pay charges in excess of the Usual & Customary (U&C) Charges. Insureds may incur significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are Insured’s responsibility.

**PRESCRIPTION DRUG BENEFIT**

The Prescription Program is available through the OptumRX Pharmacy Network. After a $10 co-payment for a 30-day supply of a generic drug, and a $20 co-payment for a 30-day supply of a brand name drug. Insured Persons will be given an ID card to show to the pharmacy as proof of coverage. If a prescription needs to be filled prior to receiving the ID card, reimbursement will be made upon submitting a completed Rx claim form (claim forms can be obtained from Consolidated Health Plans.) To locate a participating OptumRX Pharmacy, please call Consolidated Health Plans at (877) 657-5030. Not all medications are covered.

**EXTENSION OF BENEFITS**

Coverage under the Policy ends on the Termination Date shown in the Insurance Information Schedule. 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 90 days from the Termination Date while such confinement continues. The Extension of Benefits will end on the earliest of the following dates: 1. Hospitalization is not Medically Necessary; or 2. The Insured Person obtains other coverage.

**DEFINITIONS**

**Accident** means a sudden, unforeseeable external event which results independently of disease, bodily infirmity or any other cause that causes Injury to an Insured Person.  
**Ambulance Service** means transportation to a Hospital by an Ambulance Service.  
**Anesthetist** means a Physician or nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the procedure is performed.  
**Brand Name Drugs** means drugs for which the drug manufacturer’s trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the package label.  
**Coinsurance** means the ratio by which We and the Insured Person share in the payment of expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.  
**Complications of Pregnancy** means conditions that require Hospital confinements before the pregnancy ends. And whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.  
Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.) Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.  
**Copayment** means the amount of expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.  
**Country of Assignment** means the country in which an Eligible International Student, scholar or visiting faculty member is:  
1. Temporarily residing; and  
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.  
**Covered Injury** means a bodily injury that is caused by the Accident directly and independently of all other causes. Coverage under the School’s policies must be in force on the date the services and supplies are received for them to be considered as a Covered Medical Expense.  
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;
3. Not in excess of the PPO Allowance; and
4. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

Covered Sickness means Sickness, disease or trauma related disorder due to Injury which:
1. causes a loss while the Policy is in force; and
2. which results in Covered Medical Expenses.
Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

Deductible means the dollar amount of Covered Medical Expenses which must be paid by each Insured Person before benefits are payable under the Policy. The amount of the Deductible and the frequency (annual or per occurrence) will be shown in the Schedule of Benefits.

Dependent means:
1. An Insured Student’s lawful spouse or lawful Domestic Partner;
2. An Insured Student’s dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student’s unmarried biological or adopted child or stepchild who has reached age 26 and who is:
   a. Primarily dependent upon the Insured Student for support and maintenance; and
   b. Incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.
   Proof of the child’s incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

Elective Surgery or Elective Treatment means surgery or medical treatment that is:
1. Not necessitated by a pathological or traumatic change in the function or structure of any part of the body; and
2. Which occurs after the Insured Person’s effective date of coverage.

Elective Treatment include, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, learning disabilities and routine physical exams. This also includes premarital exams, 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 include, but is not limited to, circumcision, breast reduction and gender reassignment surgery. This also includes submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

Emergency Medical Condition means a medical condition which:
1. manifests itself by acute symptoms of sufficient severity (including severe pain); and
2. causes a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect that the absence of immediate medical attention might result in:
   a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily functions; or
   c. Serious dysfunction of any bodily organ or part.

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

Essential Health Benefits mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.
**Generic Drugs** means a drug that is identical or equivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

**Habilitation/Habilitative Services** means health care services that help the Insured Person keep, learn, or improve skills and functions for daily living. Habilitative Services may include such services as physical therapy, occupational therapy, and speech therapy.

**Home Country** means the Insured Student’s country of citizenship. If the Insured Student has dual citizenship, his or her Home Country is the country of the passport he or she used to enter the United States. The Insured Student’s Home Country is considered the Home Country for any dependent of an Insured Student while insured under the Policy.

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

**Hospital** means an institution that:
1. Operates as a Hospital pursuant to law;
2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients;
3. Provides 24-hour nursing service by Registered Nurses on duty or call;
4. Has a staff of one or more Physicians available at all times; and
5. Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis.

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

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

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

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

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

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

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

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

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

**Morbidly Obese** means a body mass index (*BMI*) greater than 40 kg/m2 or a BMI greater than 35 kg/m2 with at least one clinically significant obesity related disease such as diabetes mellitus, obstructive sleep apnea, coronary artery disease, or hypertension for which these complications or disease are not controlled by best practice medical management.

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

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

**Physician** means a: Doctor of Chiropractic (D.C.), Doctor of Dentistry (D.M.D. or D.D.S.), Doctor of Medicine (M.D.), Doctor of Optometry (O.D.), Doctor of Osteopathy (D.O.), or 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 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 and social workers. This also includes psychiatric nurses to the extent that their services would be covered if performed by a Physician.

**PPO Allowance** means the amount a Network Provider will accept as payment in full for Covered Medical Expenses. **Preferred Brand Drug** means a formulary drug that is within a select subset of therapeutic classes, which make up the formulary drug list. **School or College** means the college or university attended by the Insured Student **Stabilize** means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

**Substance Use Disorder** means any condition or disorder that substantially limits the life activities of the Insured Person with the disorder. Substance Use Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization. **Treatment** means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services. It also includes medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions therefor.

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

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

### SCHEDULE OF BENEFITS

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

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

Non-Network: Deductible, Coinsurance, and any Copayment are applicable to Preventive Services provided through a Non-Network Provider. Any Deductible, Coinsurance, and Copayment for services provided by a Non-Network Provider are not applied toward the annual Out-of-Pocket Maximum. Benefits are paid at 80% of the Usual and Reasonable charge.

<table>
<thead>
<tr>
<th>Deductible:</th>
<th>Network</th>
<th>$0</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Non-Network</td>
<td>$100.00</td>
</tr>
</tbody>
</table>

**Out-of-Pocket Expense Limit:**
Network Provider: Individual $6,350; Family $12,700
Non-Network Provider: Individual/No maximum; Family/No maximum
Coinsurance Amount:
Network Provider: For Covered Medical Expenses, 90% of the PPO Allowance, unless otherwise stated below.

Non-Network Provider: For Covered Medical Expenses, 80% of the Usual and Reasonable Charge, unless otherwise stated below.

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

PREFERRED PROVIDER ORGANIZATION:
To locate a First Health Provider in Your area, consult Your Provider Directory or visit the network website at www.firsthealth.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;
2. ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND
3. DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.

<table>
<thead>
<tr>
<th>BENEFITS PER COVERED INJURY/SICKNESS</th>
<th>IN-NETWORK</th>
<th>NON-NETWORK</th>
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<tbody>
<tr>
<td><strong>INPATIENT BENEFITS</strong></td>
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<tr>
<td>Hospital Room &amp; Board Expenses</td>
<td>90% of PPO Allowance</td>
<td>80% of Usual &amp; Reasonable (U&amp;R)</td>
</tr>
<tr>
<td>Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room &amp; Board Expenses</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Hospital Miscellaneous Expenses for services &amp; supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts &amp; temporary surgical appliances, oxygen, blood &amp; plasma, misc. supplies</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Preadmission Testing</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Physician’s Visits while Conferred</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Inpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Registered Nurse Services for private duty nursing while confined</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Physical Therapy (inpatient)</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Inpatient Rehabilitation Benefit</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Skilled Nursing Facility Expense Benefit</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Mental Health Disorder</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Substance Use Disorder</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td><strong>OUTPATIENT BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Surgery:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgeon Services</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Assistant Surgeon</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
</tr>
<tr>
<td>-------------------------------------</td>
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<td>-------------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient Surgery Miscellaneous</strong></td>
<td><strong>90% of PPO Allowance</strong></td>
<td><strong>80% of U&amp;R</strong></td>
</tr>
<tr>
<td>(excluding not-scheduled surgery) -- expenses for services &amp; supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood &amp; plasma</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Therapy</strong> including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy</td>
<td><strong>100% of PPO Allowance for Covered Medical Expenses Copayment $15</strong></td>
<td><strong>80% of U&amp;R Copayment $15</strong></td>
</tr>
<tr>
<td><strong>Habilitative Services</strong> are covered to the extent that they are Medically Necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services Expenses</strong></td>
<td><strong>90% of PPO Allowance Copayment $100 Copayment waived if admitted</strong></td>
<td><strong>90% of PPO Allowance for Covered Medical Expenses Copayment $100 Copayment waived if admitted</strong></td>
</tr>
<tr>
<td><strong>In Office Physician’s Visits</strong> includes care by Primary Physician, specialist, and any other licensed practitioner operating within the scope of his or her license</td>
<td><strong>100% of PPO Allowance for Covered Medical Expenses Copayment $15</strong></td>
<td><strong>80% of Usual and Reasonable Charge for Covered Medical Expenses Copayment $15</strong></td>
</tr>
<tr>
<td><strong>Urgent Care Centers or Facilities</strong></td>
<td><strong>90% of PPO Allowance Copayment $100 Copayment waived if admitted</strong></td>
<td><strong>90% of PPO Allowance for Covered Medical Expenses Copayment $100 Copayment waived if admitted</strong></td>
</tr>
<tr>
<td><strong>Diagnostic X-ray Services</strong></td>
<td><strong>90% of PPO Allowance</strong></td>
<td><strong>80% of U&amp;R</strong></td>
</tr>
<tr>
<td><strong>Laboratory Procedures (Outpatient)</strong></td>
<td><strong>90% of PPO Allowance</strong></td>
<td><strong>80% of U&amp;R</strong></td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td><strong>100% of PPO Allowance for Covered Medical Expenses Generic Copayment: $10 Brand Copayment: $20 See Prescription Card Copays apply to a 30-day supply</strong></td>
<td><strong>N/A</strong></td>
</tr>
<tr>
<td><strong>Outpatient Miscellaneous Expense</strong> for services not otherwise covered but excluding surgery</td>
<td><strong>90% of PPO Allowance</strong></td>
<td><strong>80% of U&amp;R</strong></td>
</tr>
<tr>
<td><strong>Home Health Care Expenses</strong></td>
<td><strong>90% of PPO Allowance</strong></td>
<td><strong>80% of U&amp;R</strong></td>
</tr>
<tr>
<td><strong>Hospice Care Coverage</strong></td>
<td><strong>90% of PPO Allowance</strong></td>
<td><strong>80% of U&amp;R</strong></td>
</tr>
<tr>
<td><strong>Mental Health Disorder</strong></td>
<td><strong>100% of PPO Allowance for Covered Medical Expenses Copayment $15</strong></td>
<td><strong>80% of Usual and Reasonable Charge for Covered Medical Expenses Copayment $15</strong></td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
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<tr>
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</tr>
<tr>
<td>Substance Use Disorder</td>
<td>100% of PPO Allowance for Covered Medical Expenses Copayment $15</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses Copayment $15</td>
</tr>
<tr>
<td><strong>OTHER BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>100% of PPO Allowance for Covered Medical Expenses Copayment $50</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses Copayment $50</td>
</tr>
<tr>
<td>Braces and Appliances including Prosthesis and Orthotics</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Maternity Benefit including birthing center services and Complications of Pregnancy</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Routine Newborn Care</td>
<td>Same as any other Covered Sickness</td>
<td></td>
</tr>
<tr>
<td>Consultant Physician Services – when requested by the attending physician</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Accidental Injury Dental Treatment for Insured Persons over age 19 Subject to $350 per tooth maximum $1,000 Policy Year</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Sickness Dental Expense for Insured Persons over age 19 Subject to $100 per tooth maximum</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
</tr>
<tr>
<td>Treatment outside of the U.S.</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>Sports Accident Expense - incurred as the result of the play or practice of intramural, club or Intercollegiate sports</td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Abortion Expense Subject to $350 maximum per Policy Year</td>
<td>100% of PPO Allowance for Covered Medical Expenses</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Preventive Care, Screening, and Immunizations</td>
<td>100% of PPO Allowance for Covered Medical Expenses No cost-sharing</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Medical Evacuation Expense</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td>BENEFITS PER COVERED INJURY/SICKNESS</td>
<td>IN-NETWORK</td>
<td>NON-NETWORK</td>
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<td>-------------------------------------</td>
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</tr>
<tr>
<td>Repatriation Expense</td>
<td>100% of Usual and Reasonable Charge for Covered Medical Expenses</td>
<td></td>
</tr>
<tr>
<td><strong>Pediatric Dental Care Benefit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Dental Care - limited to 1 dental exam every 6 months</td>
<td>See Benefit for limitations 100% of PPO Allowance for Preventive Services</td>
<td>See Benefit for limitations 80% of U&amp;R for Preventive Services</td>
</tr>
<tr>
<td><strong>The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Dental</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Clinical Oral Evaluations</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Endodontic Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Periodontal Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Prosthodontic Services</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td>Medically Necessary Orthodontic Care</td>
<td>50% Usual and Reasonable</td>
<td>50% Usual and Reasonable</td>
</tr>
<tr>
<td><strong>Pediatric Vision Care Benefit</strong></td>
<td>100% of PPO Allowance for Preventive Services</td>
<td>80% of U&amp;R for Preventive Services</td>
</tr>
<tr>
<td>Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Routine Eye Care (adult)</strong></td>
<td>90% of PPO Allowance</td>
<td>80% of U&amp;R</td>
</tr>
<tr>
<td>Limited to 1 routine eye exam per Policy Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>100% of PPO Allowance for Covered Medical Expenses Copayment $15</td>
<td>80% of Usual and Reasonable Charge for Covered Medical Expenses Copayment $15</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>STATE MANDATED BENEFITS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mandate Disclaimer:</strong> 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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Infertility Treatment</strong> for medically necessary expenses of diagnosis and treatment of infertility for women between the ages of twenty-five (25) and forty-two (42) years. Infertility treatment includes assistive reproductive technologies such as in-vitro fertilization. Benefits are not payable for an Insured who has previously undergone a voluntary sterilization procedure.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>As used in this benefit, Infertility means the condition of an otherwise presumable healthy married individual who is unable to conceive or sustain a pregnancy during a period of one year.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contraceptive Coverage</strong> for F.D.A.-approved contraceptive drugs and devices which require a prescription on the same basis as other Prescription Drugs. We will not pay for the prescription Drug RU 486.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Mastectomy Treatment and Hospital Stay</strong> for expenses incurred by an Insured Person for not less than forty-eight (48) hours of inpatient care following a mastectomy and not less than twenty-four (24) hours of inpatient care following a lymph node dissection for the treatment of breast cancer. Coverage is included for expenses incurred for reconstructive breast surgery performed as a result of a partial or total mastectomy as described in the Inpatient Surgery benefit. Any such reconstructive breast surgery includes coverage for reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed. The reconstructive surgery and any adjustments made to the non-diseased breast must occur within twenty-four (24) months of reconstruction of the diseased breast. Benefits will be paid for prostheses and treatment of physical complications, including lymphademas, at all stages of mastectomy, in</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Administered by: Consolidated Health Plans 2077 Roosevelt Ave. Springfield, MA 01104
consultation with the attending Physician and the patient.

**Hair Prosthesis (Wigs)** for incurred expenses for a scalp hair prosthesis (wig) worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. Coverage is limited to $350 per hair prosthesis (wig) per Policy Year.

**Hearing Aids** for audiological services and hearing aids for Insured Persons as described in the Schedule of Benefits.

**Pediatric Preventive Care/Screening/Immunization** for expenses incurred for eligible participants who are Dependents of an Insured Student, from birth through the date the child is eighteen (18) years of age for:

a. Immunization against diphtheria, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella, haemophilus influenzae type B, and hepatitis A; and

b. Any other immunization subsequently required for children by the Rhode Island Department of Health. Benefits will not be provided for pediatric preventive care services that are paid for or offered free of charge by the state of Rhode Island. Biologicals used for vaccinations are covered by the state of Rhode Island.

**Smoking Cessation Programs** for expenses incurred for tobacco cessation treatments. This includes outpatient counseling for smoking cessation when provided by a qualified practitioner and nicotine replacement therapy or prescription drugs. Nicotine replacement therapy includes, but is not limited to nicotine gum, patches lozenges, nasal spray and inhalers.

Smoking cessation treatment includes the use of an over-the-counter (OTC) or prescription FDA smoking cessation medication, when used in accordance with FDA approval, for not more than two (2) courses of medication of up to fourteen (14) weeks each, annually, when prescribed by a qualified practitioner, and used in combination with smoking cessation counseling sessions provided by a qualified practitioner.

**Lead Poisoning** for expenses incurred for screening for lead poisoning and lead screening related services for children under six (6) years of age. Coverage includes diagnostic evaluations for lead poisoning. This includes but is not limited to confirmatory blood lead testing.

**Lyme Disease Treatment** for expenses incurred for diagnostic testing and long-term antibiotic treatment of chronic Lyme disease when determined to be Medically Necessary and ordered by a Physician after making a thorough evaluation of the patient’s symptoms, diagnostic test results and response to treatment. Treatment shall not be denied solely because such treatment may be characterized as unproven, experimental, or investigational in nature.

**Diabetes Benefit** for expenses incurred for the following equipment, supplies and related services for the treatment of Type I, Type II, and gestational diabetes, when Medically Necessary and when recommended or prescribed by a Physician:

a. blood glucose monitors,
b. blood glucose monitors to the legally blind,
c. test strips for glucose monitors,
d. visual reading and urine testing strips,
e. insulin, injection aids,
f. cartridges for the legally blind,
g. syringes
h. insulin pumps and appurtenances thereto,
i. insulin infusion devices,
j. oral agents for controlling blood sugar, and
k. therapeutic/molded shoes for the prevention of amputation,
l. prosthetic devices, up to $350 per year.

When Medically Necessary, this benefit includes coverage for:

a. self-management and treatment of the Insured Person’s diabetes. The self-management must be supervised by a Physician or an appropriately licensed, registered, or certified health care professional as part of an office visit for diabetes diagnosis or treatment. Such training may be provided in group settings when practical.
b. Physician visits relating to medical nutrition therapy:

1) upon the diagnosis of diabetes;
2) a Physician diagnosis which shows a significant change in the patient’s symptoms or conditions which require changes in a patient’s self-management; and
3) when reeducation or refresher training is necessary.

Medical nutrition therapy education must be provided by the Physician or an appropriately licensed and certified health care provider. Such education may be conducted in group settings. Coverage for self-management education and education relating to medical nutrition therapy shall also include home visits when Medically Necessary.
c. Podiatric health care provider services to prevent complications from diabetes. **Early Intervention Services** for expenses incurred for early intervention services for dependent children up to Age 3. This coverage is limited to five thousand dollars ($5,000) per dependent child.

As used in this benefit:

"Early Intervention Services" means, but is not limited to, speech and language therapy, occupational therapy, physical therapy, evaluation, case management, nutrition, service plan development and review. It also means nursing services, and assistive technology services and devices for dependents from birth to age three (3) who are certified by the department of human services as eligible for services under part C of the Individuals with Disabilities Education Act (20 U.S.C. Section 1471 et seq.).

**Enteral Nutrition Products** for non-prescription enteral formulas for home use for which a Physician has issued a written order and which are Medically Necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastro esophageal reflux, chronic intestinal pseudo-obstruction, and inherited diseases of amino and organic acids. Coverage for inherited diseases of amino and organic acids includes food products modified to be low protein. When enteral formula is delivered through a feeding tube, We will pay the expense incurred when it is the sole source of nutrition.

**Human Leukocyte Antigen Testing** Benefit for expenses incurred for testing for utilization in bone marrow transplantation. The human leukocyte antigen testing, also known as histocompatibility locus antigen testing, for A, B, and DR antigens must be performed in a facility that is accredited by the American Association of Blood Banks or its successors, and is licensed under the Clinical Laboratory Improvement Act, 42 U.S.C. § 263a.

**Mammogram and Pap Smear Benefit** for expenses incurred for Mammograms and Pap Smears. The mammogram and pap smear must be recommended by a Physician for an Insured Person who has been treated for breast cancer within the last 5 years on the same basis as other Preventive Services.

**Prostate and Colorectal Examination Benefit** for prostate and colorectal examinations and laboratory tests to detect cancer in any non-symptomatic Insured Person in accordance with current American Cancer Society guidelines.

**Approved Clinical Trial Benefit** for expenses incurred in relation to a clinical trial. We will not deny or limit or impose additional conditions on benefits for routine patient costs for items or services furnished to the Insured Person in connection with his or her participation in the Approved Clinical Trial.

As used in this benefit:

**Approved Clinical Trial** means a Phase I, Phase II, Phase III, or Phase IV clinical trial that is conducted in relation to prevention, detection, or treatment of cancer or a life-threatening disease or condition and is described in any of the following:

a. A study approved or funded by one or more of the following: federal National Institutes of Health (NIH); federal Centers for Disease Control and Prevention (CDC); federal Agency for Health Care Research and Quality (AHRQ); federal Centers for Medicare & Medicaid Services (CMS); a cooperative group or center of any of the entities described above or the U.S. Department of Defense or the U.S. Department of Veteran Affairs; a qualified non-governmental research entity identified in the guidelines by NIH for center support grants; or a study or investigation conducted by the U.S. Department of Defense or the U.S. Department of Veteran Affairs.

b. the U.S. Department of Energy;

c. The study is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration;

d. The study is a drug trial that is exempt from having such an investigational new drug application.

**Routine Patient Costs** means items and services that are usually covered for an Insured Person who is not enrolled in an Approved Clinical Trial. Routine Patient Costs do not include the investigational item, devices, or services itself; items and services that are provided solely to satisfy data collection and analysis needs and that are not used indirect clinical management of the patient; or a service that is clearly inconsistent with widely accepted, established standards of care for a particular diagnosis.

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**COORDINATION OF BENEFITS PROVISION**

The Policy will coordinate benefits for expense covered by any other valid and collectible medical, health or accident insurance or pre-payment plan as stated in the Policy. Payments from such coverage from the plan will not be in excess of the total eligible expenses incurred.

**EXCLUSIONS & LIMITATIONS**

Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of that Act. The Plan does not cover nor provide coverage for loss caused by or resulting from:
The Policy does not cover loss nor provide benefits for any of the following. That is except as otherwise provided by the benefits of the Policy and as shown in the Schedule of Benefits.

1) **International Students Only** - expenses incurred within the Insured Person’s Home Country or country of regular domicile, that exceeds the benefit amount shown in the Schedule of Benefits.

2) preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.

3) routine physical or other examinations where there are no objective indications of impairment of normal health. Except as specifically provided under the Policy.

4) dental treatment including orthodontic braces and orthodontic appliances. Except as specified for accidental Injury to the Insured Person’s Sound, Natural Teeth or as specifically covered under the Pediatric Dental Benefit.

5) services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury.

6) weak, strained or flat feet, corns, calluses or ingrown toenails.

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

8) 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.

9) loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.

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

11) charges incurred for acupuncture in any form, Except to the extent provided in the Schedule of Benefits.

12) expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses or hearing aids, except as described in the Schedule of Benefits or as required for repair caused by a Covered Injury or as specifically covered under the Pediatric Vision Benefit.

13) 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.
   - For the purposes of this provision. **Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body. This can be 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.

14) treatment to the teeth. This includes 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. Such a procedure must be considered Medically Necessary based on the Policy definition of same. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.

### THIRD PARTY REFUND

When:

1. An Insured Person is injured through the negligent act or omission of another person (the "third party"); and
2. Benefits are paid under the Policy as a result of that Injury.

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

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

### CLAIM PROCEDURES

In the event of an Injury or Sickness the Insured Person should:

1. Report to the nearest Doctor or Hospital and follow the prescribed treatment advice.
2. A claim form is not required to submit a claim. However, an itemized bill, (HCFA 1500, or UB04) should be used to submit expenses. The Insured Student/Person's name and identification number needs to be included. Providers should submit claims within ninety (90) days from the date of Accident or from the date of first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting a claim, a copy should be retained and claims should be mailed to the Claims Administrator.

3. Direct all questions regarding benefits available under this Plan, claim procedures, status of a submitted claim or payment of a claim to the Claims Administrator, Consolidated Health Plans.

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**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 one hundred eighty (180) days of the date appearing on the EOB. The appeal request must include why the Insured Person disagrees with the way the claim was processed. The request must include any additional information he/she feels supports the request for appeal, e.g. medical records, physician records, etc. Please submit all requests to the Claims Administrator, Consolidated Health Plans.

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**The Plan is Underwritten By:**
National Guardian Life Insurance Company
Madison, WI
As Policy Form NBH-280 (2016) PPO RI et al
Policy Number: 2017I5867

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

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**Claims Administrator:**
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
877-657-5030
Email: customerservice@consolidatedhealthplan.com
www.chpstudent.com
Servicing Broker:
University Health Plans, a Risk Strategies Company
(After July 10, 2017)
15 Pacella Park Drive
Randolph, MA 02368
Phone: (800) 437-6448
Fax: (617) 472-6419
www.universityhealthplans.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:
National Guardian Life Insurance Company
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502

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

Representations of this plan must be approved by the Company.

This is not the Policy. Rather, it is a brief description of the benefits and other provisions of the Policy. The Policy is governed by the laws and regulations of the state in which it is issued and is subject to any necessary State approvals. Any provisions of the Policy, as described in this brochure, that may be in conflict with the laws of the state where the school is located will be administered to conform with the requirements of that state’s laws, including those relating to mandated benefits.
VALUE ADDED SERVICES
The following services are not part of the Plan Underwritten by National Guardian Life Insurance Company. These value added options are provided by Consolidated Health Plans.

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

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