Student Health Insurance Program

Designed for the Students of

MGH Institute of Health Professions

Boston, MA

2017-2018

National Guardian Life Insurance Company

Madison, WI

Policy Number: 2017I5B17

Effective May 1, 2017 to April 30, 2018

Group Number: ST0874SH

NOTICE: Be advised that you may be eligible for coverage under your parents' plan if you are under the age of 26. If you have any questions or concerns about this notice, contact Consolidated Health Plans, 877-657-5030.

IMPORTANT NOTICE

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

NONDISCRIMINATORY

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

This health plan satisfies **Minimum Creditable Coverage standards** and **will satisfy** the individual mandate that you have health insurance. Please see page 4 for additional information.

English/English

Translators are available when You call the customer service number. Upon request We will provide interpreter and translation services related to administrative procedures.

Español/Spanish

Traductores se encuentran disponibles cuando Ud. Llama al número de atención al cliente. Si Ud. Lo requiere, podemos ofrecerle interpretes y traductores con experiencia en procedimientos administrativos.

Русский/Russian

Переводчики предоставляются после Вашего звонка по номеру обслуживания клиентов. После запроса мы предоставим устного переводчика и услуги письменного перевода, связанные с административными процедурами.

Français/French

Des traducteurs sont à votre disposition quand Vous appelez le service clientèle. Sur demande, Nous vous fournirons des services d'interprétation/traduction pour les procédures administratives.

Italiano/Italian

Sono disponibili dei traduttori qualora se ne abbia bisogno quando si contatta il servizio clienti via telefono. Se richiesto, saremmo in grado di offrire servizi di interpretariato e traduzione per i vari procedimenti amministrativi.

Português/Portuguese

Poderá obter serviços de tradução no momento de chamar o serviço à clientela. Quando solicitados, nós forneceremos serviços de interpretação e de tradução para os procedimentos administrativos.

Ελληνικά/Greek

Υπάρχουν διαθέσιμοι μεταφραστές όταν Εσείς τηλεφωνήσετε στον αριθμό εξυπηρέτησης πελατών. Όταν το ζητήσετε, Εμείς θα σας παρέχουμε με υπηρεσίες διερμηνείας και μετάφρασης σχετικά με τις διαχειριστικές διαδικασίες.

中文/Chinese

當您打電話給客服中心時，可利用翻譯員的服務。在您要求之下，

我們會提供有關行政步驟過程的口譯以及翻譯服務。

Kreyl̀/Haitian Creole

Gen Tradiktè ki la pou pale ak ou lè w rele nimewo sèvis kliyan nou an. Si w mande nou pral ba w sèvis entèprèt ak tradiktè pou pwosedi administrasyon yo.

ภาษาไทย /Khmer

អ្នកបកប្រែទាំងអស់ អាចបំពេញលោកអ្នកបាន លុះត្រាតែលោកអ្នក ទូរស័ព្ទទៅលេខ សំរាប់ការបំពេញតិចិតនៃ។ ពេលសំណើរ ត្រូវយើងទទួលរួចហើយ យើងនឹងផ្តល់ ការបំពេញផ្នែកការបកប្រែ ទាំងការបកប្រែ ពីសំណេរ ក៏ដូចជា ការបកប្រែផ្ទាល់មាត់ ទៅតាម ទំរង់ការរបស់ទីចាត់ការរៀបចំ។

ลาว/Lao

ຈະມີນາຍພາສາໃຫ້ຕົວລາທ່ານໂທຫາເບີ້ຂອງພະແນກຊ່ວຍເຫຼືອລູກຄ້າ. ພາຍມີຫຼັງການຂໍແລ້ວ ພວກເຮົາຈະໃຫ້ບໍ່ຣິການນາຍ ພາສາແປຄວາມຂ້ຳແລະແປຂອກສານ ທີ່ກ່ຽວກັບການປະຕິບັດດ້ານບໍ່ຣິຫານຕ່າງໆ.

عربي/Arabic

يتوفر لدينا مترجمون لخدمتكم عندما تتصلون هاتفيا برقم خدمة الزبائن. وبناء على طلبكم، فإننا سنقوم بتأمين مترجم شفهي وخدمات ترجمة تتعلق بالإجراءات الإدارية.

CIGNA PREFERRED PROVIDER NETWORK

By enrolling in this Insurance Program, you have access to the Cigna PPO Network. A complete listing is available at www.cigna.com.

A Preferred Provider may require an Insured Person to pay an annual fee for inclusion within the Preferred Providers panel of patients. Any services that are represented to be a part of the Preferred Provider's annual service agreement are part of that separate agreement and are not part of this Insurance Program.

THE PROGRAM DOES NOT REQUIRE YOU TO USE A PREFERRED PROVIDER.

If a Preferred Provider is not available in a particular area or specialty, the Policy will cover at the Preferred Provider level until a provider has been added.

Coverage will be provided at the Preferred Provider level for a provider who is not a Preferred Provider for the first thirty (30) days from the effective date of coverage if an Insured Person is undergoing an ongoing course of treatment or the provider is the Insured Person's primary care provider.

If the Insured Person is a female who is in her second (2nd) or third (3rd) trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily disenrolled, other than disenrollment for quality-related reasons or fraud, treatment will be allowed with said provider, according to the terms of the Policy, for the period up to and including the Insured Person's first postpartum visit.

If an Insured Person is terminally ill and the provider in connection with said Sickness is involuntarily disenrolled, other than for quality related reasons or fraud, the Insured Person will be allowed to continue treatment with said provider, according to the terms of the Policy, until the death of the Insured Person.

Continued coverage is conditioned upon the provider agreeing to:

- Accept reimbursement at the rates applicable prior to notice of disenrollment as payment in full and not to impose cost sharing with respect to the Insured Person in an amount that would exceed the cost sharing that could have been imposed if the provider had not been disenrolled; and
- Adhere to the Policy's quality assurance standards and to provide necessary medical information related to the care provided; and
- Adhere to Our policies and procedures.

Physician profiling information may be available from the Board of Registration in Medicine for physicians licensed to practice in Massachusetts.

MGH Institute of Health Professions can access directories listing Cigna Preferred Providers by visiting www.cigna.com or www.chpstudent.com.

STUDENT ELIGIBILITY AND ENROLLMENT

To be eligible for coverage You must:

1. meet the enrollment requirements stated in the Insurance Information Schedule; and
2. pay the required premium; and
3. attend classes for at least the first 31 days of the period for which premium is paid.

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 first and second terms. 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 sixty (60) days after it expires. Otherwise, the effective date will be the first (1st) of the month following Your request. Your premium for this coverage must accompany the request. Please Note: there are no preexisting condition limitations or exclusions provided for in this health plan.

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 **will satisfy** the statutory requirements that you have health insurance meeting these standards.
THIS DOCUMENT IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE MAY 1, 2017. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST 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.

PREMIUM

The insurance under MGH Institute for Health Professions Student Health Insurance Plan for the Annual Policy is effective 12:01 a.m. on May 1, 2017. The Annual Policy terminates at 12:01 a.m. on April 30, 2018 or at the end of the period through which the premiums are paid, whichever is earlier.

	Summer 5/1/2017-8/31/2017	**Fall** 9/1/2017-12/31/2017	**Spring** 1/1/2018-4/30/2018
Student	$1,909	$1,909	$1,909
Student and Spouse	$3,818	$3,818	$3,818
Student & 1 Child	$3,818	$3,818	$3,818
Student & 2 Children	$5,727	$5,727	$5,727
Student & 3 or more Children	$7,636	$7,636	$7,636
Student, Spouse & 1 Child	$5,727	$5,727	$5,727
Student, Spouse & 2 Children	$7,636	$7,636	$7,636
Student, Spouse & 3 or more Children	$9,545	$9,545	$9,545

The above rates include a broker administrative fee.

ADVANCED NOTIFICATION

Certificate of Coverage will be issued and delivered to at least one adult insured in each household residing in Massachusetts. Prior notice of material modifications to any covered services under this health plan will be provided to the Insured, at least 60 days before the effective date of the modifications. Such notices shall include the following: (a) any changes in clinical review criteria; and (b) a statement of the effect of such changes on the personal liability of the insured for the cost of any such changes.

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 minus any claims paid.
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 90 days of withdrawal from school.

DEPENDENT ELIGIBILITY AND ENROLLMENT

Students who are enrolled in the Student Health Insurance Plan may also enroll their Dependents. Dependent coverage, if any, begins and ends with Your coverage. A Dependent newborn child will be automatically covered under the Policy from the moment of birth until the thirty-first (31st) day following birth. During the thirty-one (31) day period, We must receive written notice of the birth and the required premium must be paid. Coverage for such newborn children will consist of coverage for Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or premature birth, including 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 the regulations of the Department of Public Health. To continue coverage beyond the thirty-one (31) day period or to obtain other Dependent coverage, the Insured must notify Us in writing within thirty-one (31) days of birth, marriage, adoption, or other qualifying event, and pay the required additional Premium.

TERMINATION

Coverage will terminate at 12:01 a.m. standard time at the Policyholder's address on the earliest of:

- The Termination Date of the Policy for all Insured Persons; or
- The end of the period of coverage for which premium has been paid; or
- The date an Insured Person ceases to be eligible for the insurance; or
- The date an Insured Person enters military service; or
- On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error.

INVOLUNTARY DISENROLLMENT

The number of Insured Persons involuntarily disenrolled in the past two (2) years is zero (0).

EXTENSION OF BENEFITS

The Coverage provided ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended 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 up to the date of discharge for up to 90 days or the date of discharge, whichever is earlier.

GENERAL DEFINITIONS

The terms listed below, if used, have the meaning stated.

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

Adverse Determination means a decision, based upon a review of information provided, by Us to deny, reduce or modify a claim based on medical necessity.

Ambulance Service means transportation to a Hospital by an Ambulance Service.

Anesthetist means a Physician or nurse who administers anesthesia during a surgical procedure. He or she may not be an employee of the Hospital where the surgical procedure is performed.

Brand Name Drugs means drugs for which the drug manufacturer's trademark registration is still valid and where the trademarked or proprietary name of the drug still appears on the packaged label.

Coinsurance means the ratio by which We and the Insured Person share in the payment of Usual and Reasonable expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these. Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.) Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Copayment means the 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 and are applicable regardless of any Out-of-pocket Expense Limits. 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 this Policy or the School's prior policies; and
2. Caused by an accident directly and independently of all other causes.

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

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

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

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

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

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

Dependent means:

1. An Insured Student's lawful spouse;
2. An Insured Student's dependent biological or adopted child or stepchild under age 26; and
3. An Insured Student's biological or adopted child or stepchild who has reached age 26 and who is:
    a. primarily dependent upon the Insured Student for support and maintenance; and
    b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.

    Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when an Insured Student enrolls a new disabled child under the plan.

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

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

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

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

Emergency Medical Condition means a medical condition which:

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

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

Experimental/Investigational: The service or supply being considered or suggested has not been demonstrated in scientifically valid clinical trials and research studies to be safe and effective for a particular indication or condition.

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

Generic Drugs means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

Grievance means any oral or written complaint submitted to the carrier which has been initiated by an insured, or on behalf of an insured with the consent of the insured, concerning any aspect or action of the carrier relative, to the insured, including, but not limited to, review of Adverse Determinations regarding scope of coverage, denial of

services, rescission of coverage, quality of care and administrative operations, under the requirements of this chapter. See Complaints and Appeals.

Health Care Services means services for the diagnosis, prevention, treatment, cure or relief of a physical illness, injury or disease.

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 includes a Christian Science sanatorium which is operated or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts at the time the service is provided and which operates according to the rules and regulation of the Church.

Hospital does not include the following:

1. Convalescent homes or convalescent, rest or nursing facilities;
2. Facilities primarily affording custodial, educational, or rehabilitory care; or
3. Facilities for the aged, drug addicts or alcoholics.

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

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

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

Involuntary Disenrollment means that a carrier has terminated the coverage of the insured due to any of the reasons: 1. failure by the insured or other responsible party to make payments required under the contract; 2. misrepresentation or fraud on the part of the insured; 3. commission of acts of physical or verbal abuse by the insured which pose a threat to providers or other insureds of the carrier and which are unrelated to the physical or mental condition of the insured; provided, that the commissioner prescribes or approves the procedures for the implementation of the provisions of Massachusetts laws and regulations; 4. relocation of the insured outside the service area of the carrier; or 5. non-renewal or cancellation of the group contract through which the insured receives coverage.

Late enrollee means an eligible employee or dependent who requests enrollment in a group health plan or insurance arrangement after the plan initial enrollment period, their initial eligibility date provided under the terms of the plan or arrangement or the group's annual open enrollment period; provided, however, that an insured shall not be considered a late enrollee if the request for enrollment to the insurer is made within 30 days after termination of coverage provided under another health insurance plan or arrangement where such coverage has ceased due to termination of the spouse's employment or death of the spouse or if the request for enrollment is made pursuant to section 9A, 9C or 18 of chapter 118E.

Loss means medical expense caused by an Injury or Sickness which is covered by this Policy.

Medical Necessity or **Medically Necessary** means:

1. the service is the most appropriate available supply or level of service for the Insured Person in question considering potential benefits and harms to the individual;
2. is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
3. for services and interventions not in widespread use, is based on scientific evidence.

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

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

Nurse Practitioner means a registered nurse who holds authorization in advanced nursing practice as a nurse practitioner under M.G.L. c. 112, §80B.

Out-of-pocket Expense Limit means the amount of incurred expenses that an Insured Person is responsible for paying. Any Out-of-pocket Expense Limits applicable to this Policy are shown in the Schedule of Benefits.

Physician means a:

1. Doctor of Medicine (M.D.); or
2. Doctor of Osteopathy (D.O.); or
3. Doctor of Dentistry (D.M.D. or D.D.S.); or

4. Doctor of Chiropractic (D.C.); or
5. Doctor of Optometry (O.D.); or
6. Doctor of Podiatry (D.P.M.);

who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered. A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified Nurse Practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician. 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. The term Physician does not mean any person who is an Insured Person's spouse or the parent, child, brother or sister of the Insured Person or his or her spouse.

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

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

Skilled Nursing Facility - A facility constituted, licensed, and operated as set forth in applicable state law, which:

1. mainly provides Inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial facility or similar place.

Sound, Natural Teeth means natural teeth. The major portion of a tooth must be present, regardless of fillings, and not carious, abscessed or defective. Sound, Natural Teeth will not include capped teeth.

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

Treatment means the medical care of a Covered Injury or Covered Sickness by a Physician who is operating within the scope of his or her license. Such care includes diagnostic, medical, surgical or therapeutic services, medical advice, consultation, recommendation, and/or the taking of drugs or medicines or the prescriptions thereof.

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.

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

STUDENT HEALTH INSURANCE

This brochure is a brief description of the Student Health Insurance Plan available for all students who meet the eligibility requirement as shown above. The exact provisions governing this insurance are contained in the Master Policy underwritten by National Guardian Life Insurance Company, serviced and administered by Consolidated Health Plans.

Benefits for Covered Medical Expenses will be paid according to the Schedule of Benefits and any exclusions, limitations, or state mandated provisions as follows.

SCHEDULE OF BENEFITS	
Eligibility	Benefit Amount Payable
Annual Maximum Benefit for Non-Essential Health Benefits	Student: Unlimited Dependent: Unlimited

Preventive Services	The Deductible is not applicable to Preventive Services. Benefits for services provided by a Network Provider are paid at 100% of the PPO Allowance of Covered Medical Expenses. Benefits for services provided by a Non-Network Provider are provided at the Coinsurance Amount shown below	
Deductible	$100, Individual Coverage / $200, Family Coverage	$200, Individual Coverage / $400, Family Coverage
Out-of-Pocket Expense Limit: The most an Insured would be required to pay for covered expenses during a plan year before the coinsurance level would pay at 100%.	**In-Network** Individual $2,000- maximum amount allowed under federal law Family $4,000/maximum amount allowed under federal law	**Out of Network** Individual $4,000/ Family $8,000
Coinsurance	100% of Preferred Provider Allowance (PA) for Covered Medical Expenses In-Network	80% of Usual and Reasonable (U&R) Covered Medical Expenses Out of Network
Inpatient Benefits	**In-Network**	**Out of Network**
BENEFITS FOR COVERED INJURY/SICKNESS	**BENEFIT AMOUNT PAYABLE**	
Hospital Room & Board Expenses	The Coinsurance Amount shown above	The Coinsurance amount shown above
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Hospital Miscellaneous Expenses for services & supplies	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Preadmission Testing	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Physician's Visits while Confined:	The Coinsurance Amount shown above	The Coinsurance Amount shown above

Inpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services
Physical Therapy (inpatient)	Co-Pay: $30 then The Coinsurance Amount shown above; subject to a maximum number of visits of 60 per Policy Year	The Coinsurance Amount shown above
Outpatient Benefits	**In-Network**	**Out of Network**
BENEFITS FOR COVERED INJURY/SICKNESS	**BENEFIT AMOUNT PAYABLE**	
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services	 The Coinsurance Amount shown above The Coinsurance Amount shown above 30% of benefit for Surgeon Services
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Outpatient Facility Fee	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Short Term Rehabilitation Therapy (outpatient)	Co-Pay: $30, then the Coinsurance Amount shown above; subject to a maximum number of visits of 60 per Policy Year for Physical Therapy	The Coinsurance Amount shown above
Emergency Services Expenses In-network out of pocket maximum applies to out of network emergency services benefits	Co-Pay: $50, then 100% of PA. Co-pay waived if admitted	Co-Pay: $50, then 100% of PA Co-pay waived if admitted
Primary Care Visit to Treat an Injury or Illness (includes syringes and needles dispensed during a visit)	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Specialist Visit	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Other Practitioner Office Visit	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above

Urgent Care	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Imaging Tests	Co-Pay: $50, then the Coinsurance Amount shown above	Co-Pay: $50, then the Coinsurance Amount shown above
Diagnostic X-ray Services	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Laboratory Procedures (Outpatient)	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Outpatient Prescription Drugs	Co-Pay: subject to Generic Copay $20.00, subject to Preferred Brand Copay $30.00,- subject to Brand Copay $30.00 then Coinsurance: 100%	No Benefit
Home Health Care Expenses	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Hospice Care Coverage	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Skilled Nursing Facility Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Podiatry Care Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
TMJ Disorder Treatment	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Dialysis Services Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Other Benefits	**In-Network**	**Out of Network**
Ambulance Service - Ground and/or Air and/or water Transportation	The Coinsurance Amount shown above	100% of U&R
Braces and Appliances	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Durable Medical Equipment	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Maternity Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Routine Newborn Care	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Consultant Physician Services – when requested by the attending physician	Co-Pay: $30, then The Coinsurance Amount shown above	The Coinsurance Amount shown above
Sickness Dental Expense	The Coinsurance Amount shown above up to $300 per tooth	The Coinsurance Amount shown above up to $300 per tooth
Abortion Expense	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Medical Evacuation Expense	100% of PA	100% of U&R
Repatriation Expense	100% of PA	100% of U&R

Mandated Benefits	In-Network	Out of Network
BENEFITS FOR COVERED INJURY/SICKNESS	**BENEFIT AMOUNT PAYABLE**	
Autism Spectrum Disorder Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Cancer Treatment Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Clinical Trials Benefit for Cancer or other Life Threatening Disease	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Cardiac Rehabilitation Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Chiropractic Care Benefit	Co-Pay: $30, then the Coinsurance Amount shown above	The Coinsurance Amount shown above
Cleft Palate and Cleft Lip Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Cytologic Screening (pap smear) and Mammographic Examination	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Diabetes Equipment, Supplies and Service Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Early Intervention Services	100% of PA	100% of U&R
Fitness Benefit	Up to 2 months of membership to a Fitness Facility, at least $150 per policy year	Up to 2 months of membership to a Fitness Facility, at least $150 per policy year
Hormone Replacement Therapy Services; Outpatient Contraceptive Services. Same as other prescription drugs or devices	Co-Pay: subject to Generic Copay $20.00, subject to Preferred Brand Copay $30.00, subject to Brand Copay $30.00, then Coinsurance of 100%	**No coverage out of network**
Human Leukocyte Testing	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Infertility Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Mastectomy Surgery and Rehabilitation Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above

Mental Illness Benefit (Paid same as any other Sickness)	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Morbid Obesity & Bariatric Surgery Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Non-Prescription Enteral Formula and Low Protein Food Formulas	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Organ Transplant Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Oxygen and Respiratory Therapy Benefit (for home use)	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Pediatric Dental Care Benefit	100% of PA for Preventive	The Coinsurance Amount shown above
Pediatric Vision Care Benefit	100% of PA for Preventive	The Coinsurance Amount shown above
Pediatric Specialty Care	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Prosthetic Devices	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Telemedicine Consultation Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Treatment of Speech, Hearing, and Language Disorders Benefit	The Coinsurance Amount shown above	The Coinsurance Amount shown above
Hearing Aid for Children Benefit	Maximum $2,000 for each hearing aid every 36 months	Maximum $2,000 for each hearing aid every 36 months
Weight Loss Program Benefit	Up to 2 months of membership to a Fitness Facility	Up to 2 months of membership to a Fitness Facility

BENEFITS

Benefits are payable under the policy only for those Covered Medical Expenses incurred while the policy is in effect as to the Insured Person. The Covered Medical Expenses for an issued Policy will be only listed in the Schedule of Benefits. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under the Extension of Benefits. Subject to payment of any required Deductible, when you suffer a loss from a Covered Accident or Covered Sickness, we will pay benefits as follows:

Preventive Services: The following services shall be covered without regard to a Deductible, Copayment, or Coinsurance requirement that would otherwise apply:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) - http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved.
3. With respect to Insured Persons who are infants, children, adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health and Resources Administration.
4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (1.) As provided in the comprehensive guidelines supported by the Health Resources and Services Administration.

Treatment of Covered Injury or Covered Sickness: We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person for Loss due to Covered Injury or Covered Sickness. Benefits are subject to: 1) Maximum Benefit for Covered Injury or Covered Sickness: 2) Any specified benefit maximum amounts; 3). Any Deductible amounts; 4) Any Coinsurance amount; 5) Any Copayments; 6) The Maximum Out-of-Pocket Expense Limit; and 7) Use of a Network Provider, if any.

INPATIENT BENEFITS

Benefits are subject to applicable deductible, coinsurance, and co-payments as outlined in the Schedule of Benefits.

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. We will provide coverage for a private room charge when deemed Medically Necessary for an Insured Person. If a private room is used but not approved in advance, the Insured Person must pay all costs that are greater than the semi-private room rate.

Intensive Care Unit, including 24-hour nursing care. **This benefit is NOT payable in addition to room and board charges incurred on the same date.**

Hospital Miscellaneous Expenses, while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:

a. The cost for use of an operating room;
b. Prescribed medicines;
c. Laboratory tests;
d. Therapeutic services;
e. X-ray examinations;
f. Casts and temporary surgical appliances;
g. Oxygen, oxygen tent;
h. Blood and blood plasma; and
i. Miscellaneous supplies.

Preadmission Testing - We will pay the charges for routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital. These tests must be performed within 5 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

Physician's Visits while Confined – We will pay the expenses incurred for Physician's visits not to exceed one visit per day. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit. Whenever a location is part of the Cigna PPO Network, the Insurer shall cover medically necessary covered benefits delivered at that location and the Insured shall not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by Non-network Providers, unless the Insured has a reasonable

opportunity to choose to have the service performed by a Network Provider.

Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services – We will pay benefits for inpatient surgery (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the inpatient surgery benefit or the Outpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value and 50% of the cost of the second procedure. This benefit is not payable in addition to Physician's visits.

Physical Therapy while Confined - We will pay the expenses incurred for physical therapy when prescribed by the attending Physician.

OUTPATIENT BENEFITS

Benefits are subject to applicable deductible, coinsurance, and co-payments as outlined in the Schedule of Benefits.

Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services – We will pay benefits for outpatient surgery (including fees for pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the outpatient surgery benefit or the inpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value and 50% for the second procedure. Outpatient Surgery does not include coverage for removal of wisdom teeth, whether or not imbedded in bone.

Outpatient Surgery Miscellaneous - (excluding non-scheduled surgery) surgery performed in a hospital emergency room, trauma center, physician's office, outpatient surgical center or clinic. Benefits will be paid for services and supplies, including:

a. Operating room;
b. Therapeutic services;
c. Oxygen, oxygen tent;
d. Blood and blood plasma; and
e. Miscellaneous supplies.

Outpatient Facility Fee – We will pay the expenses for outpatient facilities, including an ambulatory surgical center, for outpatient surgeries and procedures not including: removal of wisdom teeth whether or not imbedded in bone.

Short Term Rehabilitation Therapy – We will pay the expenses incurred for a physical therapy, speech/language therapy, occupational therapy, or an organized program of these combined services when provided by a physical therapist, an occupational therapist, a licensed speech-language pathologist, or a recognized expert in specialty pediatrics. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Emergency Services Expenses - Only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization. No Insured Person will, in any way, be discouraged from using the local pre-Hospital emergency medical service system, the 911 telephone number or its local equivalent.

Primary Care Visit to Treat an Injury or Illness – We will pay for services at a Primary Care Visit.

Specialist Visit – We will pay for services at a Specialist Visit.

Other Practitioner Office Visit– We will pay for services at Other Practitioner Office Visits such as nurse or Physician assistant.

Urgent Care – We will pay the expenses incurred for Urgent Care as shown in the Schedule of Benefits. Urgent Care is medical, surgical, or psychiatric care that is needed right away to prevent serious deterioration of health when an unforeseen illness or injury occurs. In most cases, Urgent Care will be brief diagnostic care and treatment to stabilize.

Imaging Tests – We will pay the expenses incurred for Imaging Tests including: fluoroscopic tests and their interpretation; and the taking and interpretation of roentgenograms and other imaging studies that are recorded as a permanent picture, such as film. Some examples of imaging tests are: magnetic resonance imaging (MRI); computerized axial tomography (CT scans); positron emission tomography (PET scans); and nuclear cardiac imaging tests. These types of tests also include diagnostic tests that require the use of radioactive drugs.

Diagnostic X-ray Services – We will provide coverage for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a physician.

Laboratory Procedures (Outpatient) – We will provide coverage for laboratory procedures as shown in the

Schedule of Benefits when prescribed by a Physician.

Prescription Drugs -

a. We will pay the expenses incurred for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made. Benefits include hypodermic needles or syringes required for the administration of a prescription drug.

b. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:

i. The drug is approved by the FDA;

ii. The drug is prescribed for the treatment of a life-threatening condition including but not limited to cancer or human immunodeficiency virus or acquired immunodeficiency syndrome (AIDS/HIV);

iii. The drug has been recognized for treatment of that condition by one of the following:

(a) The American Medical Association Drug Evaluations;

(b) The American Hospital Formulary Service Drug Information.

(c) The United State Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or

(d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items i., ii., and iii. of this benefit.

As it pertains to this benefit, life threatening means either or both of the following:

(a) Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or

(b) Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.

c. Specialty Drugs - "Specialty Drugs" are Prescription Drugs which:

i. Are only approved to treat limited patient populations, indications, or conditions; or

ii. Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or

iii. Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

d. Step Therapy - When medications for the treatment of any medical condition are restricted for use by a step therapy or fail-first protocol, the prescribing practitioner shall have access to a clear and convenient process to request an override of the restriction from Us. An override of that restriction will be granted by Us within forty-eight (48) hours, if all necessary information to perform the override review has been provided, under the following documented circumstances:

i. The prescribing practitioner can demonstrate, based on sound clinical evidence, that the preferred treatment required under step therapy or fail-first protocol has been ineffective in the treatment of the Insured Person's disease or medical condition; or

ii. Based on sound clinical evidence or medical and scientific evidence:

(a) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the insured and known characteristics of the drug regimen; or

(b) The prescribing practitioner can demonstrate that the preferred treatment required under the step therapy or fail-first protocol will cause or will likely cause an adverse reaction or other physical harm to the Insured Person.

The duration of any step therapy or fail-first protocol shall not be longer than a period of thirty (30) days if the treatment is deemed and documented as clinically ineffective by the prescribing practitioner. When the prescribing practitioner can demonstrate, through sound clinical evidence, that the originally prescribed medication is likely to require more than thirty (30) days to provide any relief or an amelioration to the insured, the step therapy or fail-first protocol may be extended up to seven (7) additional days.

Home Health Care Expense - We will pay the charges incurred for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary.

Hospice Care Coverage - When, as the result of a Covered Injury or Covered Sickness, an Insured Person requires hospice care under a Hospice Care Program, We will pay the Usual and Reasonable expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six (6) months.

As used in this benefit:

Hospice Care Hospice Care Program means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing and other health services through home or inpatient care during the illness and bereavement to:

a. Individuals who have no reasonable prospect of cure as estimated by a Physician; and
b. The immediate families or family caregivers of those individuals.

Skilled Nursing Facility Benefit - We will the expenses incurred for items and services provided as an inpatient in a skilled nursing bed of Skilled Nursing Facility or hospital, including room and board in semi-private accommodations. This coverage includes rehabilitative services; and drugs, biologicals, and supplies furnished for use in the Skilled Nursing Facility and other medically necessary services and supplies. Custodial or residential care in a Skilled Nursing Facility or any other facility is not covered except as rendered as part of Hospice Care.

Podiatry Care Benefit – We will pay the expenses incurred for foot care provided by a Physician or podiatrist including: diagnostic lab tests and x-rays, surgery and necessary postoperative care, and other Medically Necessary foot care (such as treatment for hammertoe and osteoarthritis). We will **not** provide coverage under this benefit for: routine foot care services such as trimming of corns, trimming of nails, and other hygiene care, except when Medically Necessary because of systemic circulatory diseases (such as diabetes), and certain non-routine foot care services and supplies such as: foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes that are not part of a leg brace (except for those shown as covered in the Schedule of Benefits) and fittings, castings, and other services related to devices for the feet.

TMJ Disorder Benefit – We will pay the expenses incurred to diagnose and/or treat temporomandibular joint (TMJ) disorders that are caused by or result in a specific medical condition (such as degenerative arthritis and jaw fractures or dislocations). The medical condition must be proven to exist by means of diagnostic x-ray tests or other generally accepted diagnostic procedures. This coverage includes:

- Diagnostic x-rays.
- Surgical repair or intervention.
- Non-dental medical care services to diagnose and treat a TMJ disorder.
- Splint therapy. (This also includes measuring, fabricating, and adjusting the splint.)
- Physical therapy. (See "Short-Term Rehabilitation Therapy.")

We will not provide coverage for: TMJ disorders that are not proven to be caused by or to result in a specific medical condition; appliances, other than a mandibular orthopedic repositioning appliance (MORA); and services, supplies, or procedures to change the height of teeth or otherwise restore occlusion (such as bridges, crowns, or braces).

Dialysis Services Benefit – We will pay the expenses incurred for dialysis when it is provided by a hospital, community health center, free-standing dialysis facility, or by a Physician.

Outpatient Miscellaneous Expenses (Excluding surgery) - We will pay the charges actually incurred for miscellaneous outpatient expenses (excluding surgery) incurred for the treatment and care of a Covered Injury or Covered Sickness. Expenses must be incurred on the advice of a Physician. Miscellaneous outpatient expenses include other reasonable expenses for services and supplies that have been prescribed by the attending Physician.

OTHER BENEFITS

Benefits are subject to applicable deductible, coinsurance, and co-payments as outlined in the Schedule of Benefits.

Ambulance Service – We will pay the expenses incurred for transportation to or from a Hospital by ground and/or air and/or water ambulance.

Braces and Appliances - When prescribed by the attending Physician for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We will also not pay for braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

Durable Medical Equipment - We will pay the expense incurred for the rental or purchase of durable medical

equipment, including, but not limited to, Hospital beds, wheel chairs, and walkers. We will pay the lesser of either the rental or purchase charges, but not both. Should the Insured Person choose durable medical equipment that costs more than the lesser value of either rental or purchase, We will pay only the costs that would have been paid for the least expensive equipment. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable medical equipment must:

a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
b. Be able to withstand repeated use; and
c. Generally not be useful to a person in the absence of Injury or Sickness.

Durable Medical Equipment does not include foot orthotics, medical supplies, or equipment not designed to serve a medical purpose.

Maternity Benefit - We will pay the expenses incurred for maternity charges as follows:

a. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness. Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.
b. **Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.
c. **Physician-directed Follow-up Care** including:
    1) Physician assessment of the mother and newborn;
    2) Parent education;
    3) Assistance and training in breast or bottle feeding;
    4) Assessment of the home support system;
    5) Performance of any prescribed clinical tests; and
    6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

This benefit will apply to services provided in a medical setting or through home health care visits. Any home health care visit must be provided by an individual knowledgeable and experienced in maternity and newborn care. All home health care visits that are made necessary by early discharge from the Hospital must be performed within 72 hours after discharge. When a mother or a newborn receives at least the number of hours of inpatient care shown in item "a", the home health care visit benefit will apply to follow-up care that is determined to be necessary by the health care professionals responsible for discharging the mother or newborn.

d. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness. Whenever a location is part of the Cigna PPO Network, the Insurer shall cover medically necessary covered benefits delivered at that location and the Insured shall not be responsible to pay more than the amount required for network services even if part of the medically necessary covered benefits are performed by Non-network Providers, unless the Insured has a reasonable opportunity to choose to have the service performed by a Network Provider.

Routine Newborn Care - If expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:

a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
b. Inpatient Physician visits for routine examinations and evaluations;
c. Charges made by a Physician in connection with a circumcision;
d. Routine laboratory tests including lead screening;
e. Postpartum home visits prescribed for a newborn;
f. Follow-up office visits for the newborn subsequent to discharge from a Hospital, and
g. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the treatment of such newly born child.

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

Sickness Dental Expense Benefit - If, by reason of Sickness, an Insured Person requires treatment for impacted wisdom teeth, We will pay the Covered Percentage of the Covered Charges incurred for the treatment. Benefits not to exceed the amount shown in the Schedule of Benefits.

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

Medical Evacuation and Repatriation - To be eligible for this benefit, a Student must: a) be an International Student enrolled in the authorized college or school during the period for which coverage is purchased; or b) be an Eligible Domestic Student participating in a study abroad program, sponsored by the College or School, that is 100 miles from away from the Student's primary residence.

An eligible **International Student** must meet the definition of same. An International Student may also enroll his or her Dependent under this Section by payment of additional premium.

As used in this Section, an **Eligible Domestic Student** means a permanent resident of the United States who is enrolled at the college or school and who is temporarily participating in international educational activities outside their Home Country.

The maximum combined benefit for Medical Evacuation and Repatriation is shown in the Schedule of Benefits.

Medical Evacuation Expense – If:

a. an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness;

b. that occurs while he or she is covered under this Policy,

We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or the Insured Person's Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

a. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of five (5) days immediately prior to medical evacuation;

b. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;

c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;

d. No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person's insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination;

e. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and

f. Transportation must be by the most direct and economical route.

Repatriation Expense- If the Insured Person dies while he or she is covered under this Policy, We will pay a benefit. The benefit will be the necessary Usual and Reasonable charges for preparation, including cremation, and transportation of the remains to the Insured Person's place of residence in his or her Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

STATE MANDATED BENEFITS

Benefits are subject to applicable deductible, coinsurance, and co-payments as outlined in the Schedule of Benefits.

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 purposes 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.

Autism Services Provider means a person, entity or group that provides treatment of Autism Spectrum Disorders.

Board Certified Behavior Analyst means a behavior analyst credentialed by the behavior analyst certification

board as a board certified behavior analyst.

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. We will pay for one new machine produced (synthetic) with adjustable back prosthesis or one hand-tied ready-made synthetic or processed human hair prosthesis annually. Such prosthesis shall be the most appropriate, cost effective solution to the Insured's hair loss. The Insured must have a written prescription from the treating Physician for a scalp hair prosthesis. This benefit is subject to the same Usual and Reasonable limitations and guidelines as any other prosthesis covered by this Policy.
4. 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.
5. 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).

Clinical Trials Benefit for Cancer or other Life-Threatening Disease - We will pay the Usual and Reasonable expenses incurred for Patient Care Services in connection with a qualified cancer or life-threatening disease 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.

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 this Policy.

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

1. The clinical trial is intended to treat cancer or other life-threatening disease 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, Ill 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 Medically Necessary laboratory tests will be covered in accordance with the terms and conditions of this Policy.

Cleft Palate and Cleft Lip Benefit - We will pay the Usual and Reasonable expenses incurred for an Insured Person under the age of 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. preventive 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 the same as any other screening. 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. However, if benefits are also provided under the Preventive Services Benefit, We will pay only under one benefit, which 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; and
    c. Therapeutic molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating Physician and prescribed by a podiatrist or other qualified Physician and furnished by a podiatrist, orthotist, prosthetist or pedorthist.
3. We will also pay Reasonable and Customary charges for diabetes outpatient self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including medical nutrition therapy when provided by a certified diabetes health care provider. This benefit will be limited to visits where a Physician diagnoses a significant change in the Insured Person's symptoms or conditions that necessitate changes in an Insured Person's self-management or where reeducation or refresher education is necessary. Coverage also includes home visits. Such education may be provided by certified diabetes health care provider, which means:
    a. A licensed health care professional with expertise in diabetes;
    b. A registered dietician; or
    c. A health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

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 Medically Necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or Medically Necessary 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 (6) years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child's first year after birth, three (3) times during the next year, annually until age six (6). 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. Medically Necessary 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 Medically Necessary 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.
4. Reimbursement of costs for such services shall be part of a basic benefits package offered by Us or a third party. This benefit is not subject to Copayments, Coinsurance or Deductibles.
5. 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 in each Policy Year for each membership fee paid to a health club membership or for fitness classes at a health club for up to two months of a twelve month of membership or at least $150 per policy 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.

Home Health Care Expense - We will pay the charges incurred for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary.

As used in this benefit, “Home Health Care” shall mean health care services for a patient provided by a public of private home health agency which meets the standards of service of the purchaser of service, provided in a patient’s residence; provided, however, that such residence is neither a hospital nor an institution primarily engaged in providing skilled nursing or rehabilitation services. Said services shall include, but not be limited to, nursing and physical therapy. Additional services such as occupational therapy, speech therapy, medical social work, nutritional consultation, the services of a home health aide and the use of durable medical equipment and supplies shall be medical equipment and supplies shall be provided to the extent such additional services are determined to be a medically necessary component of said nursing and physical therapy. Benefits for home care services shall apply only when such services are medically necessary and provided in conjunction with a physician approved home health services plan.

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) and Intrauterine Insemination (IUI).
2. In Vitro Fertilization and Embryo Transfer (IVF-ET).
3. Gamete Intra fallopian Transfer (GIFT).
4. Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any.
5. Intracytoplasmic Sperm Injection (ICSI) for the treatment of male factor infertility.
6. Zygote Intrafallopian Transfer (ZIFT).
7. Assisted Hatching.
8. Cryopreservation of eggs.

Infertility means the condition of an Insured Person who is unable to conceive or produce conception during a period of 1 year if the female is age 35 or younger or during a period of 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 1 year or 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

Mastectomy Surgery and Rehabilitation Benefit - The surgical procedure known as a mastectomy will be covered under the Surgery Benefit of this Policy. Under this benefit We will pay the expenses incurred for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Insured Person following a covered mastectomy.

As used in this benefit, prosthetic device includes the initial prosthetic device and any subsequent prosthetic devices provided pursuant to an order of the Insured Person's Physician and surgeon.

Mental Illness Benefit- We will pay the Usual and Reasonable expenses incurred for the diagnosis and treatment of the following Biologically-Based Mental Disorders as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM:

1. schizophrenia;
2. schizoaffective disorder;
3. major depressive disorder;
4. bipolar disorder;
5. paranoia and other psychotic disorders;
6. obsessive-compulsive disorder;
7. panic disorder;
8. delirium and dementia;
9. affective disorders;
10. eating disorders;
11. post traumatic stress disorder;
12. substance abuse disorders; and
13. Autism.

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 to Massachusetts law.

We will also pay the Usual and Reasonable expenses for covered children and adolescents under the age of 19 for the diagnosis and treatment of non-Biologically-Based Mental Disorders or other behavioral or emotional disorders which substantially interfere with or substantially limit the functioning and social interactions of such a child or adolescent. Such interference or limitation is documented by and the referral for said diagnosis and treatment is made by the primary care provider, primary pediatrician or a licensed mental health professional of such a child or adolescent or is evidenced by conduct, including, but not limited to:

1. an inability to attend school as a result of such a disorder;
2. the need to hospitalize the child or adolescent as a result of such a disorder; or
3. a pattern of conduct or behavior caused by such a disorder which poses a serious danger to self or others.

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

Inpatient confinement will mean that the Insured Person must be confined in an either:

A general Hospital licensed to provide such services;

A facility under the direction and supervision of the Department of Mental Health;

A private mental Hospital licensed by the Department of Mental Health; or

A substance abuse facility licensed by the Department of Public Health.

Intermediate services means a range of non-inpatient services that provide more intensive and extensive treatment interventions when Outpatient Services alone are not sufficient to meet the patient's needs. Intermediate Services include, but are not limited to:

Acute and other residential treatment;

Partial Hospitalization;

Day treatment;

In-home therapy services;

Clinically managed detoxification services;

1. Intensive Outpatient Programs; and Crisis Stabilization.

Outpatient Services 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. Consultations 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. Per visit limits for non-Biologically-Based Mental Disorder services do not apply to Biologically-Based Mental Disorders.

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 incurred for non-prescription enteral formulas which when recommended by the Insured

Person's Physician for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction and inherited diseases of amino acids and organic acids.

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 Medically Necessary 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 for the following covered services for Insured Students and Dependent children up to age 19.

1. **Preventive and Diagnostic Services**, including: comprehensive evaluation, periodic oral exams, limited oral evaluation, oral evaluation under 3 years of age, x-rays, cleaning, fluoride treatments, space maintainers, sealants.
2. **Basic Covered Services**, including: amalgam restorations, composite resin restorations, recement crown/onlay, dentures, root canals on permanent teeth, prefabricated stainless steel crowns, periodontal scaling and root planing, simple and surgical extractions, vital pulpotomy, apicoectomy, palliative care, anesthesia.
3. **Major Restorative Services,** including: resin crown, porcelain/ceramic crowns, porcelain fused to metal/noble/high noble crowns, partial and complete dentures.
4. **Orthodontia**. Orthodontia is covered only when a Doctor of Dentistry determines that orthodontia is medically necessary because of severe and handicapping malocclusion of the teeth.

If a Preferred Provider is not available in a particular area or specialty of pediatric dental care, the Policy will cover at the Preferred Provider level until a provider has been added.

Pediatric Vision Care Benefit- We will pay the Usual and Reasonable expenses incurred for one Visual Examination per Policy Year 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 Medically Necessary as evidenced by appropriate documentation. The vision examination must be performed by an ophthalmologist or by an optometrist.

Pediatric Specialty Care Benefit – We will pay the Usual and Reasonable expenses incurred for pediatric specialty care, including mental health care by a Physician, as defined in this contract, with recognized expertise in specialty pediatrics to insureds requiring such services.

Prosthetic Devices Benefit- We will pay the Usual and Reasonable expense incurred for Prosthetic Devices and repairs under the same terms and conditions that apply to other durable medical equipment covered under the Policy. For 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 purposes 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, and Language Disorders Benefit- We will pay the Usual and Reasonable expenses incurred in the diagnosis and treatment of speech, hearing and language disorders. This coverage includes hearing exams and speech/language therapy. 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.

Hearing Aids for Children: We will also provide coverage for the expenses incurred in the purchase of a hearing aid for an Insured Person 21 years of age or younger when prescribed or recommended by a licensed Physician. Benefits include the related services of fitting, adjustments and supplies, including ear molds when prescribed by a

licensed audiologist or hearing instrument specialist. 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. We pay the full cost of one (1) hearing aid per hearing impaired ear, up to $2,000 for each hearing aid every 36 months.

Weight Loss Program Benefit - We will reimburse an Insured Person for up to two months of twelve month membership or at least $150 per policy year for fee paid to a hospital-based weight loss program or for non-hospital-based weight loss programs sponsored by the School. The weight loss program benefit is available to the Insured Student and any other enrolled Insured Persons.

GENERAL EXCLUSIONS AND LIMITATIONS

Unless specifically included, no Benefits will be paid for: a) loss or expense caused by, contributed to, or resulting from; b) treatment, services, or supplies for, at, or related to:

1. medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
2. dental treatment including orthodontic braces and orthodontic appliances, except as specified for Insured Persons under age 19 or for accidental injury to the Insured Person's Sound, Natural Teeth.
3. professional services rendered by an immediate family member or anyone who lives with the Insured Person.
4. services or supplies not related to the medical care of the Insured Person's Injury or Sickness.
5. 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.
6. weak, strained or flat feet, corns, calluses or ingrown toenails.
7. treatment of acne.
8. expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
9. any expenses in excess of Usual and Reasonable charges.
10. 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.
11. 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.
12. loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate, intramural or club sports.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport;
14. 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.
15. Injury sustained as the result of the Insured Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
16. Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
17. Treatment or care for weight increase or weight loss, except as specifically provided in the Schedule of Benefits.
18. expenses for hair growth or removal unless otherwise specifically covered under the Policy.
19. racing or speed contests, skin diving or sky diving, ultra light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
20. expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    a. For the purposes of this provision**, Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    b. For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance).
21. treatment to the teeth, including surgical extractions of teeth Except as specifically provided in the

Schedule of Benefits.

22. an Insured Person's:
    a. committing or attempting to commit a felony,
    b. being engaged in an illegal occupation, or
    c. participation in a riot.
23. custodial care service and supplies.
24. Specific non-life threatening surgeries including but not limited to: non-endocrine or pulmonary related Hysterectomy, Salpingo-oophorectomy, Vaginectomy, Metoidioplasty, Scrotoplasty, Urethroplasty, placement of testicular prostheses (except when related to injury or disease process), Phalloplasty, Orchiectomy, Penectomy, Vaginoplasty, Clitoroplasty, Labiaplasty unless determined to be medically necessary by a physician practicing within the scope of his or her license.
25. expenses that are not recommended and approved by a Physician.
26. Physician's charges for diagnosis and treatment of structural imbalance, distorting or subluxation in vertebral column or elsewhere in body by manual, mechanical means, through muscular-skeletal adjustments, manipulations, and related modalities. Except as specifically provided in the Schedule of Benefits.
27. Personal convenience items such as modifications to dwellings or property that may increase the value of the residents or automobile, regardless of therapeutic value.
28. Non-Prescription drugs or medicines such as legend vitamins, minerals, food supplements, herbs, herbal formulas, biological sera, except as specifically provided in the Schedule of Benefits.
29. Acupressure, aroma therapy, hypnosis, hyperhidrosis (excessive sweating), rolfing type services, reflexology, biofeedback, alternative health care except as specifically provided.
30. Vocational recreation: art, dance, poetry, music, or other similar-type therapies.
31. Pregnancy that results under a surrogate parenting agreement.
32. Treatments and resulting complications the American Medical Association (AMA), consider to be unsafe, Experimental, or Investigational.

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.

COORDINATION OF BENEFITS

If the Insured Person is insured under more than one group health plan, the benefits available under this plan may be coordinated with other benefits available to the Insured Person under any other coverage. The Plan pays in accordance with the rules set forth in the Policy on file with the Policyholder.

CLAIM PROCEDURES

Written notice of a claim must be given to Us within 90 days after the date of Injury or commencement of Sickness covered by this Policy, or as soon thereafter as is reasonably possible. Notice given by or on behalf of the claimant to Our authorized agent, with information sufficient to identify the Insured Person will be deemed notice to Us.

We, upon receipt of a notice of claim, will furnish to the claimant such forms as are usually furnished by Us for filing proofs of loss. If these forms are not given to the claimant within 15 days, the claimant will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limits stated in the Proofs of Loss provision.

Written proof of Loss must be furnished to Us or to our authorized agent within 90 days after the date of such Loss. If it was not reasonably possible to give written proof in the time required, We may not reduce or deny the claim for this reason if the proof is filed as soon as reasonable possible. The proof required must be given no later than one year from the time specified unless the claimant was legally incapacitated.

Indemnities payable under this Policy will be paid immediately upon receipt of due proof of such Loss.

Benefits will be paid to the Insured Person. Loss of life benefits, if any, will be payable in accordance with the beneficiary designation in effect at the time of payment. If no such designation or provision is then effective, the benefits will be payable to the estate of the Insured Person. Any other accrued indemnities unpaid at the Insured Person's death may, at Our option, be paid either to such beneficiary or to such estate.

If benefits are payable to the estate of an Insured Person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $1,000.00, to any one relative by blood or connection by marriage of the Insured Person who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision will fully discharge Us to the extent of such payment.

We may pay all or a portion of any indemnities provided for health care services to the provider, unless the Insured Person directs otherwise, in writing, by the time proofs of loss are filed. We cannot require that the services be rendered by a particular provider.

If payment is not made within forty-five (45) days of proof of loss, you will be notified in writing with the reasons for nonpayment or whatever further documentation is needed for payment of said claims. Interest will be paid on the benefits beginning forty-five (45) days after receipt of the claim at the rate of 1.5% per month, not to exceed 18% per year.

Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 452-5370 or
Toll Free (877)657-5030
www.chpstudent.com
Group Number: ST0874SH

SUBMIT ALL MEDICAL CLAIMS TO:
Cigna
PO Box 188061
Chattanooga, TN 37422 – 8061
Electronic Payor ID: 62308

You may request and will obtain within 2 working days information regarding estimated or maximum allowed amounts or charges for a proposed admission, procedure, or service by calling the toll-free number above or by accessing the website www.chpstudent.com. You can also access up to date information about your plan, including amendments, Provider directory, privacy notice, and rights and responsibilities at the above website address.

COMPLAINT AND APPEAL PROCEDURES

To file a complaint or to appeal a claim, send a letter stating the issue to Consolidated Health Plan's Appeal Department at the below address. Include your name, phone number, address, school attended and email address, if available.

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 452-5370 or
Toll Free (877) 657-5030
www.chpstudent.com

Massachusetts consumers and other individuals who receive health coverage from a Massachusetts insurer are entitled to protections covering internal grievances, medical necessity guidelines, continuity of care and independent external reviews. You have the right to appeal to the Office of Patient Protection at 1-800-436-7757, fax: 1-617-624-5046 or visit www.state.ma.us/dph/opp.

Under certain circumstances, You also have a right to an external appeal of a denial of coverage. To file an external appeal, you must file a written request to the Health Policy Commission, Office of Patient Protection, Two Boylston Street, 6th Floor, Boston, MA 02116. Request for an external appeal must be done within 45 days of a final written notice of the final grievance determination.

If You need help filing an internal appeal or external review, Your state's Consumer Assistance Program (CAP) or Department of Insurance may be able to help You. You also have the right to obtain a report regarding grievance from the Office of Patient Protection whose contact information is listed above. To find help in Your state, go to www.HealthCare.gov/consumerhelp and click on Your state. The HealthCare.gov website also has information about other consumer protections and health care coverage options created by the Affordable Care Act.

Servicing Broker:
UNIVERSITY HEALTH PLANS, INC.
15 Pacella Park Drive
Randolph, MA 02368
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

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

The Plan is underwritten by:
NATIONAL GUARDIAN LIFE INSURANCE COMPANY
Policy Form Number: NBH-280 (2014)PPO MA

Policy Number: 2017I5B17
For a copy of the Company's privacy policy go to:
www.consolidatedhealthplan.com/about/hipaa

Administered by:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
(413) 452-5370or
Toll Free (877) 657-5030
www.chpstudent.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.)

Note: The time you were covered under this plan may count as creditable coverage under State and Federal Law if you leave this plan and go to an employer's plan within 63 days thereafter. You are eligible to receive a certification from the Company regarding the periods you were covered. Please contact the Local Administrator listed in this brochure when you need such certification.

Representations of this plan must be approved by Us.

IMPORTANT

THIS CERTIFICATE IS INTENDED ONLY FOR QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE AS DESCRIBED IN THE MASTER POLICY WHICH CONTAINS COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE AT THE COLLEGE.

National Guardian Life Insurance Company
It's about people.

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

AMENDMENT TO DEFINITIONS

This Amendment makes the revisions listed below to the Policy and Certificate to which it is attached.

The definition of Accident is deleted in its entirety and replaced with the following:
Accident means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

The definition of Covered Injury is deleted in its entirety and replaced with the following:
Covered Injury means a bodily injury that is caused by the Accident directly and independently of all other causes. Coverage under the School's policies must be in force on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

This Amendment is subject to all terms, conditions and provisions of the Policy/Certificate that are not inconsistent with it. Except as stated in this Amendment, it does not change or affect any other terms of the Policy and Certificate.

This Amendment takes effect on the same date as the Policy.

Signed for National Guardian Life Insurance Company, at its Home Office in Madison, Wisconsin.

Kimberly A. Shaul
Secretary

Mark L. Solverud
President

VALUE ADDED SERVICES

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

VISION DISCOUNT PROGRAM

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, 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.

Your out-of-pocket costs may be lower when you utilize Cigna PPO Providers. For a listing of Cigna PPO Providers, go to www.cigna.com or contact Consolidated Health Plans at (413) 452-5370, toll-free at (877) 657-5030, or www.chpstudent.com for assistance.

Administered by:

Consolidated Health Plans
2077 Roosevelt Ave.
Springfield, MA 01104