WASHINGTON COLLEGE

# Student Health Insurance Plan

**Plan Year 17/18**

***Designed Exclusively for the Students of:***

## Washington College

Chestertown, MD

2017 - 2018

***Underwritten by:***

National Guardian Life Insurance Company
Madison, WI

Policy Number: 2017I5B23

Group Number: ST0973SH

Effective: 8/15/2017 - 8/14/2018

***Administered by:***

Consolidated Health Plans
2077 Roosevelt Ave | Springfield, MA

CHP Student HEALTH

ST0973SH-1718(Bro.)

Please read the brochure carefully for information on coverage, limitations, etc. Questions should be directed to the local agent, University Health Plans 800-437-6448, or the Administrative Agent Consolidated Health Plans at 877-657-5030.

**COVERAGE**

1. Accident and Sickness coverage begins on August 15, 2017, or the date of enrollment in the plan, whichever is later and ends August 14, 2018.
2. Benefits are payable during the Policy Term, subject to any Extension of Benefits. Should a student graduate or leave College for any reason, except to enter active military service, the coverage will continue in effect to the end of the Policy Term for which premium has been paid. If the student enters military service, coverage will terminate immediately and a prorated premium refund will be made on request.
3. The Policy provides benefits based on the type of health care provider the Insured Student and his or her Covered Dependent selects. The Policy provides access to both Network Providers and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers, as shown in the Schedule of Benefits.

This certificate is not a Medicare supplement certificate. It is not designed to fill the 'gaps' of Medicare. If you are eligible for Medicare, review the Medicare supplement buyer's guide available from Us.

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

We hereby certify that the eligible student of the Policyholder is insured for losses resulting from accident or sickness, to the extent stated herein, under the provisions of policy form NBH-280 (2015) PPO MD. ("the Policy").

**Table of Contents**



**Section 1 — Definitions**

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

**Accident** means a sudden, unforeseeable external event that causes Injury to an Insured Person.

**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.

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

1. Federally funded trials where the study or investigation is approved or funded by one or more of the following entities - The National Institutes of Health, The Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, The Centers for Medicare & Medicaid Services, cooperative group or center of any of the entities listed herein or the Department of Defense or the Department of Veterans Affairs, a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants, or any of the following if the conditions that follow are met – Department of Veterans Affairs, Department of Defense, or Department of Energy;
2. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or
3. The study or investigation is a drug trial that is exempt from having an investigation drug application.

The conditions imposed on the Department of Veterans Affairs, Department of Defense, or Department of Energy for an Approved Clinical Trial require that the study or investigation be reviewed and approved through a system of peer review where the Secretary of such Department determines it to be:

1. Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
2. Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

**Body mass index** means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

**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 expenses for treatment. The Coinsurance percentage that We will pay is stated in the Schedule of Benefits.

**Congenital or Genetic Birth Defect** means a defect existing at or from birth, including a hereditary defect.

Congenital or genetic birth defect includes, but is not limited to:

1. Autism or an autism spectrum disorder;
2. Cerebral palsy;
3. Intellectual disability;

4. Down syndrome;
5. Spina bifida;
6. Hydroencephalocele; and
7. Congenital or genetic developmental disabilities.

**Copayment or Co-Pay** means the amount of expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.

**Country of Assignment** means the country in which an Eligible International Student, scholar, and/or their covered Dependents is: 1. Temporarily residing; and 2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

**Covered Injury** means a bodily injury caused by an Accident directly and independently of all other causes for which medical treatment is required by an Insured Person while he/she is insured under this Policy or the School's prior policies.

**Covered Medical Expense** means those charges for any treatment, service or supplies that are: 1. Not in excess of the PPO Allowance for treatment, services, or supplies that are received from Network Providers or Usual and Reasonable charges if such treatment, services, or supplies are received from Non-Network providers; 2. Not in excess of the charges that would have been made in the absence of this insurance; and 3. Incurred while the Policy is in force as to the Insured Person, except with respect to any expenses payable under the Extension of Benefits Provision.

**Covered Sickness** means, subject to the Extension of Benefits provisions, Sickness, disease or trauma related disorder due to Injury which: 1. Causes a loss while the Policy is in force; and 2. Which results in Covered Medical Expenses.

Covered Sickness includes Mental Health Disorders and Substance Abuse Disorders.

**Deductible** means the Covered Medical Expenses which must be incurred by each Insured Person before becoming eligible for Policy benefits. The amount of the Deductible and the frequency (annual or per occurrence) will be shown in the Schedule of Benefits.

**Domestic Partner** means an individual who is:

1. 18 years old or older;
2. Not realated to the Insured Person by blood or marriage within four degrees of consanguinity under civil law;
3. Not married or in a civil union or domestic partner another individual;
4. Has been financially interdependent with the Insrued Person for at least 6 months prior to enrollment and during that 6i months each individual contributes to some extent to the other's maintenance and support with the intention of remaining in the relationship indefinitely;
5. Shares a common primary residence with the Insured.

**Elective Surgery or Elective Treatment** means surgery or medical treatment that is not Medically Necessary and that is: 1. Not necessitated by a pathological or traumatic change in the function or structure of any part of the body as determined by the treating physician; 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 unless Medically Necessary to treat Morbid Obesity, learning disabilities, routine physical examinations (unless otherwise covered under the Preventive Services Benefit), fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to, circumcision, , breast reduction except as related to a mastectomy, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

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

**Emergency Services** means, with respect to an Emergency Medical Condition: transportation services, including but

not limited to ambulance services, and covered inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services available to the emergency department to evaluate such Emergency Medical Condition and such further medical examination and Treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3).

**Essential Health Benefits** mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories: 1. Ambulatory patient services; 2. Emergency services; 3. Hospitalization; 4. Maternity and newborn care; 5. Mental health and substance use disorder services, including behavioral health treatment; 6. Prescription drugs; 7. Rehabilitative and habilitative services and devices; 8. Laboratory services; 9. Preventive and wellness services and chronic disease management; and 10. Pediatric services, including oral and vision care.

**Family Counseling** with regards to Hospice Care means counseling given to the immediate family or family caregiver of the terminally ill Insured for the purpose of learning to care for the Insured and to adjust to the death of the Insured.

**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.

**Habilitative Services** means Physician prescribed health care services and health care devices that assist an Insured Person in partially or fully acquiring or improving skills and functioning and that are necessary to address a health condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment, including occupational therapy, physical therapy, and speech therapy. We also cover treatment of a child with a Congenital or Genetic Birth Defect to enhance the child's ability to function.

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

**Hospital** means an institution that: 1. Operates as a Hospital pursuant to law; 2. Operates primarily for the reception, care and treatment of sick or injured persons as inpatients; 3. Provides 24-hour nursing service by Registered Nurses on duty or call; 4. Has a staff of one or more Physicians available at all times; and 5. Provides organized facilities for diagnosis, treatment and surgery either on its premises or in facilities available to it on a prearranged basis. Hospital does not include the following: 1. Convalescent homes or convalescent, rest or nursing facilities; 2. Facilities primarily affording custodial, educational, or rehabilitory care; or 3. Facilities for the aged, drug addicts or alcoholics.

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

**Immediate Family Member** means the Insured Person and his or her spouse or the parent, child, brother or sister of the Insured Person or his or her spouse. With regard to Hospice Care, **Immediate family** means the spouse, parents, siblings, grandparents, and children of the terminally ill Insured Person.

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

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

**International Student** means an international student: 1. With a current passport and a student Visa; 2. Who is temporarily residing outside of his or her Home Country; and 3. Is actively engaged, on a full time basis, as a student or in educational research activities through the Policyholder. In so far as this Policy is concerned, permanent residents or those who have applied for Permanent Residency Status are not considered to be an International Student.

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

**Medically Necessary** means medical treatment that is appropriate and rendered in accordance with generally accepted standards of medical practice. Only the Insured Person's treating Physician determines if the medical treatment provided is Medically Necessary.

**Mental Health Disorder** means a condition or disorder that substantially limits the life activities of the Insured Person

with the disorder. Mental Health Disorders must be listed in the most recent version of either the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association or the International Classification of Disease Manual (ICD) published by the World Health Organization.

**Morbid Obesity** means a Body Mass Index that is:

1. Greater than 40 kilograms per meter squared; or
2. Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

**Medical Support Notice** means a notice that is in a format prescribed by Federal law and issued by a child support agency to enforce the health insurance coverage provisions of a child support order.

**Order** means a ruling that: 1) is issued by a court of Maryland or another state or an administrative agency of another state; and 2) creates or recognizes the right of a child to receive benefits under a parent's health insurance coverage; or 3) establishes a parent's obligation to pay child support and provide health insurance coverage for a child.

**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.

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

**Physician** means a: 1. Doctor of Medicine (M.D.); or 2. Doctor of Osteopathy (D.O.); or 3. Doctor of Dentistry (D.M.D. or D.D.S.); or 4. Doctor of Chiropractic (D.C.); or 5. Doctor of Optometry (O.D.); or 6. Doctor of Podiatry (D.P.M.) who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered. A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine. **Physician** will also mean any licensed practitioner who is performing a service that is within his or her lawful scope of practice. This includes an acupuncturist, a certified nurse practitioner, a certified nurse anesthetist, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician. With regard to mental health and substance abuse treatment providers, Physician includes professional services by licensed professional mental health and substance use practitioners when acting within the scope of their licenses such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists providing diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. The term Physician does not mean any person who is an Immediate Family Member.

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

**Preferred Brand Drug** means a formulary drug that is within a select subset of therapeutic classes, which make up the formulary drug list.

**Qualified Individual** means an individual who is covered under the Policy and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a Qualified Individual, there is an additional requirement that a determination be made that the individual's participation in the Approved Clinical Trial is appropriate to treat the disease or condition. That determination can be made based on the referring Physician's conclusion or based on the provision of medical and scientific information by the Qualified Individual.

**Respite Care,** with regard to Hospice Care means temporary care provided to the terminally ill Insured to relieve the family caregiver from the daily care of the Insured.

**Routine Patient Costs** as they relate to an Approved Clinical Trial means all items and services consistent with Covered Medical Expenses provided under the Policy for a Qualified Individual for treatment of cancer or another life threatening disease or condition who is not enrolled in a clinical trial. However, costs associated with the following are excluded from coverage: a. The cost of the investigational item, device or service; b. The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; and c. The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

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

**Skilled Nursing Facility** means an institution or a distinct part of an institution, licensed by the Department of Health and Mental Hygiene that is:

1. Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care or rehabilitation services for rehabilitation of injured, disabled, or sick persons;
2. Certified by the Medicare Program as a skilled nursing facility.

3. Is not a place primarily for the care of the aged, custodial or domiciliary care, or treatment of alcohol dependency;
4. Is not a rest, educational or custodial facility or similar place; and
5. Provides care supervised by a Physician.

**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.

**Student Health Center or Student Infirmary** means an on campus facility that provides: 1. Medical care and treatment to Sick or Injury students; and 2. Nursing services. A Student Health Center or Student Infirmary does not include: 1. Medical, diagnostic and treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or 2. Inpatient care.

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

**Total Disability or Totally Disabled,** as it applies to the Extension of Benefits provision, means: 1. With respect to an Insured Person, who otherwise would be employed: a.) His or her complete inability by reason of injury or sickness to perform each and every duty pertaining to the Insured Person's occupation; b.) With care and treatment by a Physician for the Covered Injury or Covered Sickness caused the inability. 2. With respect to an Insured Person who is not otherwise employed: a.) His or her inability to engage in the normal activities of a person of like age and sex; with b.) Care and treatment by a Physician for the Covered Injury or Covered Sickness causing the inability; or c.) His or her Hospital confinement or home confinement at the direction of his or her Physician due to a Covered Injury or a Covered Sickness, except for visits to receive medical treatment.

**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. In Maryland, the Usual and Reasonable charge for certain hospital specific and service specific rates is determined by the Health Services Cost Review Commission.

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

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

**You, Your** means a student of the Policyholder who is eligible and insured for coverage under the policy.

**Section 2 – Eligibility, Enrollment and Termination**

All full-time students who are taking 12 or more credit hours are automatically enrolled in this Plan at registration and the premium for coverage is added to their tuition bill, unless proof of comparable coverage is provided.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence, and online courses do not meet the Eligibility requirements that the student actively attend classes. The Company maintains the right to investigate Eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company determines the Eligibility requirements have not been met, its only obligation is to refund premium.

To complete the Waiver process, please go to www.univhealthplans.com, and follow the directions.

For enrollment or waiver questions please contact University Health Plans directly at 1-800-437-6448 or info@univhealthplans.com.

| | Annual 8/15/17 – 8/14/18 | Spring 1/15/18– 8/14/18 |
|---|---|---|
| **Student*** | $1,320 | $766 |

**The above rates include an administration fee.*

**Termination Dates:** An Insured Person's insurance will terminate on the earliest of: 1.) The date this Policy terminates for all insured persons; or 2.) The date an Insured Person ceases to be eligible for the insurance; or 3.) The date an Insured Person enters active military service and is no longer a student; or 4.) For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks); 5.) For International Students, the date the student ceases to meet Visa requirements;. 6.) The last day of the Grace Period, if the Policyholder fails to pay the required premium for an Insured Person, except as the result of an inadvertent error.

**Grace Period:** The Policyholder is entitled to a grace period of 31 days for the payment of any premium due except the first, during which grace period the coverage shall continue in force. This does not apply when We do not intend to renew the Policy beyond the period for which premium has been accepted and notice of the intention not to renew is delivered to the group Policyholder at least 45 days before the premium is due.

**Extension of Benefits:** Coverage under this Policy ceases on the Termination Date shown in the Insurance Information Schedule. We will extend coverage for persons who terminated as described below unless: 1. coverage is terminated because an Insured Person failed to pay a required premium; 2. coverage is terminated for fraud or material misrepresentation by the Insured Person; or 3. any coverage provided by a succeeding health benefit plan that: a. is provided at a cost to the individual that is less than or equal to the cost to the individual of the extended benefit required under this provision; and b. does not result in an interruption of benefits.

If an Insured Person is Totally Disabled when the coverage terminates, We will continue to pay covered benefits for expenses incurred by the Insured Person for the condition causing the disability until the earlier of: 1. the date the individual ceases to be Totally Disabled; or 2. 12 months after the date coverage terminates. We may at any time require the Insured Person to provide proof of total disability.

If an Insured Person has a claim in progress when the Insured Person's coverage terminates, We shall continue to pay covered benefits related to that claim until the earlier of: 1. the date the individual is released from the care of a Physician for the condition that is the basis of the claim; or 2. 12 months after the date coverage terminates.

If an Insured Person is confined in a Hospital on the date coverage terminates, We shall continue to pay covered benefits for the confinement until the earlier of: 1. the date the individual is discharged from the Hospital; or 2. 12 months after the date coverage terminates.

If an Insured Person is undergoing dental treatment due to a Covered Sickness or Covered Injury at the time the Insured Person's coverage terminates, coverage will continue for a course of treatment for 90 days after the date coverage terminates if the treatment: 1. begins before the date coverage terminates; and b. requires two (2) or more visits on separate days to a dentist's office.If an Insured Person is undergoing orthodontia treatment that is covered under the Policy, coverage will continue: 1. for 60 days after the date coverage terminates if the orthodontist has agreed to or is receiving monthly payments; or 2. until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the orthodontist has agreed to accept or is receiving payments on a quarterly basis.

If an Insured Person has ordered glasses or contact lenses before the date the individual's coverage terminates, the Policy will continue to provide the covered benefits that were in effect on the date the coverage terminated for the glasses or contact lenses if the glasses or contact lenses are received within 30 days after the date of the order.

**Section 3 — BENEFITS**

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

**Preventive Services:** The following services shall be covered without regard to any Deductible, 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, except that the current recommendation of the U.S. Preventive Services Task Force regarding breast cancer screening, mammography, and preventive breast cancer shall be considered the most current other than those issued in or around November 2009; 2. Immunizations that have in effect a recommendation from the Advisory Committee on

Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved; 3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; 4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

**Essential Health Benefits:** Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, treatment or services are added to the list of Essential Health Benefits by a governing authority, the policy benefits will be amended to comply with such changes.

**Treatment of Covered Injury or Covered Sickness:** We will pay benefits for Covered Medical Expenses that are incurred by the Insured Person due to a Covered Injury or Covered Sickness. Benefits payable are subject to: 1. Any specified benefit maximum amounts; 2. Any Deductible amounts; 3. Any Coinsurance amount; 4. Any Copayments; 5. The Maximum Out-of-Pocket Expense Limit; and 6. the Exclusions and Limitations provision.

**Benefit Period:** The first treatment of a Covered Injury or Covered Sickness must begin within the time stated in the Benefit Period shown in the Schedule of Benefits. A Benefit Period begins when the Insured Person experiences a Loss due to Covered Injury or Covered Sickness. The Benefit Period terminates at the end of the period defined in the Schedule of Benefits. Any extension of a Benefit Period, if provided elsewhere in the Policy, is limited to medical treatment of the Covered Injury or Covered Sickness that is ongoing on the termination date of the Insured Person's coverage. The Insured Person's termination date of coverage as it would apply to any other Covered Injury or Covered Sickness will not be affected by such extension.

**Out-of-Pocket Expense Limit:** The Out-of-Pocket Expense Limit is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. The Insured Person's Deductibles, Copayments and Coinsurance amounts will apply toward the Out-of-Pocket Expense Limit.

**Preferred Provider Organization (PPO)**

If an Insured Person uses a Network Provider, the Policy will pay the Coinsurance percentage of the PPO Allowance shown in the Schedule of Benefits for Covered Medical Expenses

If a Non-Network Provider is used, the Policy will pay the percentage of the Usual and Reasonable Covered Medical Expense shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be the responsibility of the Insured Person. Benefits for services provided by an on-call Physician or Hospital-based Physician will be paid according to Maryland law. The on-call Physician or hospital-based Physician will not balance-bill the Insured Person.

The Usual and Reasonable Covered Medical Expense amount paid to a Non-Network Provider will not be less than the PPO Allowance paid to a similarly licensed Network Provider for the same health care service in the same geographic region.

Note, however, that We pay at the PPO Allowance level for treatment by a Non-Network Provider and will calculate the Insured Persons cost-sharing amount at the Network Provider Level if:

1. There is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider.
2. There is not a Network Provider who has the professional training and expertise to treat the condition or disease or if access to a Network Provider with appropriate expertise cannot be provided without unreasonable delay or travel; or
3. The Insured Person, the Insured Person's parent, guardian, designee, or health care provider requests to continue to receive health care services by a Non-Network Provider at the time the Insured Person transitions to this Plan. The Insured Person may continue to receive services for:
   a. Acute or serious chronic such as bone fractures, joint replacements, heart attacks, cancer, HIV/AIDS, and organ transplants;
   b. Pregnancy;
   c. Mental health Disorders and Substance Use Disorders.

The Insured Person may continue to receive services for the conditions listed above for the lesser of the course of treatment or 90 days. For pregnancy, the duration of three trimesters of the pregnancy and the initial postpartum visit

An Insured Person should be aware that Network Provider Hospitals may be staffed with Non-Network Providers.

Receiving services from a Network Provider Hospital does not guarantee that all charges will be paid at the Network Provider level of benefits. It is important that the Insured Person verify that his or her Physicians are Network Providers each time he or she calls for an appointment or at the time of service.

| **SCHEDULE OF BENEFITS** | | |
|---|---|---|
| Benefit Period | Policy term | |
| | **Network** | **Non-Network** |
| Preventive Services | The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of the actual charge when services are provided through a Network Provider. | Benefits are paid at 80% of the Usual and Reasonable charge |
| Deductible | $100 | $100 |
| Out-of-Pocket Expense Limit | Individual<br>$2,500 | Individual<br>$2,500 |
| Coinsurance Amount | 90% of PPO Allowance for Covered Medical Expenses unless otherwise stated below. | 70% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below. |
| **BENEFITS PER COVERED INJURY/SICKNESS** | **NETWORK** | **NON-NETWORK** |
| **ESSENTIAL HEALTH BENEFITS** | | |
| Care in Physician's Offices | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| **Inpatient Hospital Services** | | |
| Hospital Room & Board Expenses | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room & Board Expenses | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Hospital Miscellaneous Expenses | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Preadmission Testing | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |

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| Physician's Visits while Confined | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Inpatient Surgery:<br>Surgeon Services<br><br>Anesthetist<br><br>Assistant Surgeon | <br>90% of PPO Allowance for Covered Medical Expenses<br><br>90% of PPO Allowance for Covered Medical Expenses<br><br>90% of PPO Allowance for Covered Medical Expenses | <br>70% of Usual and Reasonable Charge for Covered Medical Expenses<br><br>70% of Usual and Reasonable Charge for Covered Medical Expenses<br><br>70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Registered Nurse Services for private duty nursing while confined | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| **Outpatient Hospital Services** | | |
| Outpatient Surgery:<br>Surgeon Services<br><br>Anesthetist<br><br>Assistant Surgeon | <br>90% of PPO Allowance for Covered Medical Expenses<br><br>90% of PPO Allowance for Covered Medical Expenses<br><br>90% of PPO Allowance for Covered Medical Expenses | <br>70% of Usual and Reasonable Charge for Covered Medical Expenses<br><br>70% of Usual and Reasonable Charge for Covered Medical Expenses<br><br>70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Outpatient Miscellaneous Expense for services otherwise not covered, but excluding surgery | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| **ADDITIONAL ESSENTIAL HEALTH BENEFITS** | | |
| Emergency Services Expenses | 90% of PPO Allowance for Covered Medical Expenses | The greater of 90% of PPO Allowance for Covered Medical Expenses, the Usual and Reasonable Charge for Covered Medical Expenses, or the amount that would be paid under Medicare Part A or Part B |
| Ambulance Service | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |

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| Preventive Services | 100% of actual charge | 80% of Usual and Reasonable Charge |
| Home Health Care Expenses | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Hospice Care Coverage | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Durable Medical Equipment | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Outpatient Laboratory and Diagnostic Services | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Habilitative Services for Adults over age 19<br>Physical Therapy per condition: unlimited visits per Policy Year<br>Occupational Therapy per condition: unlimited visits per Policy Year<br>Speech Therapy per condition: unlimited visits per Policy Year | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Rehabilitative Therapy<br>Physical Therapy: unlimited visits per condition per Policy Year<br>Occupational Therapy: unlimited visits per condition per Policy Year<br>Speech Therapy: unlimited visits per condition Policy Year | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Chiropractic Care | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Skilled Nursing Facility Expense Benefit | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Infertility Services | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Nutritional Counseling and Therapy | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |
| Transplant Services | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |

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| Medical Food for Metabolic Disorders | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |
| Family Planning Services – Female | 100% of actual charge | 80% of actual charge |
| Family Planning Services – Male Sterilization | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Habilitative Services for Children Ages 0-19 | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Pregnancy and Maternity Services<br>Inpatient hospitalization of at least:<br>48 hours for uncomplicated vaginal delivery<br>96 hours for uncomplicated cesarean section | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |
| Prescription Drugs<br>Prescription Card:<br>Applies ☒<br>Does not apply ☐ | See Prescription Card – 100% Coinsurance with Copayment:<br>Generic Copayment: $10.00<br>Preferred Brand Copayment: $25.00<br>Brand Copayment: $50.00<br>Specialty Drug Copayment: $50.00<br>If no Prescription Card, 90% of the PPO Allowance stated above | If no Prescription Card,<br>70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Routine Patient Costs for Clinical Trials Benefit | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |
| Diabetes Equipment, Supplies, and Training Expenses | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |
| Mastectomy and Reconstructive Breast Surgery including Prosthesis | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |
| General Anesthesia/Facility Charges for Dental Care | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Cost of Hearing Aids for Minor Children Ages 0 to 18 | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Treatment for Morbid Obesity | Same basis as any other Covered Sickness | Same basis as any other Covered Sickness |

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| Pediatric Dental Care Benefit<br>Preventive Dental Care<br>- limited to 2 dental exams per year<br>*The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:*<br>Emergency Dental<br>Clinical Oral<br>Evaluations<br>Endodontic Services<br>Periodontal Services<br>Prosthodontic<br>Services<br>Medically Necessary Orthodontic Care<br>1 athletic mouth guard per Policy Year<br>1 occlusal guard per Policy Year | See Benefit for limitations<br>100% of actual charge for preventive services<br><br>50% of PPO Allowance<br>50% of PPO Allowance<br><br>50% of PPO Allowance<br>50% of PPO Allowance<br>50% of PPO Allowance<br><br>50% of PPO Allowance<br><br>50% of PPO Allowance<br><br>50% of PPO Allowance | |
| Pediatric Vision Care Benefit<br>Limited to 1 visit(s) per year and 1 pair of prescribed lenses and frames or one pair of contact lenses per year | 100% of PPO Allowance for preventive services | 80% of Usual and Reasonable Charge for preventive services |
| Cardiac Rehabilitation Benefit | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Pulmonary Rehabilitation Benefit | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| Mental Health Disorder and Substance Use Disorder Benefit | 90% of PPO Allowance for Covered Medical Expenses | 70% of Usual and Reasonable Charge for Covered Medical Expenses |
| **ADDITIONAL OPTIONAL BENEFITS** | | |
| Medical Evacuation Expense – (International Students and/or their Dependents and Domestic Student participating in a study abroad program) | 100% of Usual and Reasonable Charge for Covered Medical Expenses | |
| Repatriation Expense – (International Students and/or their Dependents and Domestic Student participating in a study abroad program) | 100% of Usual and Reasonable Charge for Covered Medical Expenses | |

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

Principal Sum for Double Dismemberment or Loss of Life .....$1,000.00
½ Principal Sum for Single Dismemberment .....$500.00

Loss must occur with 90 days of the date of a covered Accident.

Only one benefit will be payable under this provision, that providing the largest benefit, when more than one loss occurs as the result of any one Accident. This benefit is payable in addition to any other benefits payable under the Policy

**Essential Health Benefits**

Essential Health Benefits are not subject to annual or lifetime dollar limits. If additional specific care, treatment or services are added to the list of Essential Health Benefits by a governing authority, the policy benefits will be amended to comply with such changes.

Essential Health Benefits: Covered services include:

- **Care in Physician's offices** for treatment of Covered Sickness or Covered Injury. Surgeon fees are NOT payable under this benefit.

- **Inpatient Hospital services** including but not limited to Hospital Room and Board Expense and general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed in the Schedule of Benefits. When confined to a Maryland Hospital, benefits will be provided at the Coinsurance Amount based of the rate approved by the Maryland Health Services Cost Review Commission. When Confined to a Hospital outside of the State of Maryland, benefits will be provided at the Coinsurance Amount without regard to the rate approved by the Maryland Health Services Cost Review Commission.

  Hospital 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.

  Blood and blood plasma, including derivatives, components, biologics and serums to include autologous services, whole blood, red blood cells, platelets, immunoglobulin, and albumin.

  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; and
  h. Miscellaneous supplies.

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

  Physician's Visits while Confined due to a Covered Sickness or Covered Injury. 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.

  Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services- benefits for inpatient surgery (including pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will

be paid under either the Inpatient Surgery Benefit or the Outpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician's visits. Benefits include diagnostic and surgical procedures involving a bone or joint of the face, neck, or head when Medically Necessary to treat a condition caused by congenital deformity, disease, or injury. This coverage does not apply to intraoral prosthetic devices.

- **Outpatient Hospital services** including but not limited to:
  Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services - benefits for outpatient surgery (including fees for pre- and post-operative visits) as specified in the Schedule of Benefits. Covered surgical expenses will be paid under either the Outpatient Surgery Benefit or the Inpatient Surgery Benefit. They will not be paid under both. If two or more surgical procedures are performed through the same incision or in immediate succession at the same operative session, We will pay a benefit equal to the benefit payable for the procedure with highest benefit value. Benefits include diagnostic and surgical procedures involving a bone or joint of the face, neck, or head when Medically Necessary to treat a condition caused by congenital deformity, disease, or injury. This coverage does not apply to intraoral prosthetic devices.
  We will pay for blood and blood plasma, including derivatives, components, biologics, and serums to include autologous services, whole blood, red blood cells, platelets, immunoglobulin, and albumin.
  Outpatient Surgery Miscellaneous - (excluding emergency 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;

  Outpatient Miscellaneous Expenses (Excluding surgery) - charges for outpatient services corresponding to inpatient services provided to the Insured Person because of a request by the attending physician for an inpatient admission. 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.

- **Emergency Services** for Emergency Medical Conditions.

- **Ambulance Services** to or from the nearest Hospital where needed medical services can appropriately be provided. Benefits for Non-Network ambulance service will be paid according to Maryland Law. The Non-Network ambulance services will not balance-bill the Insured Person if the Non-Network ambulance service obtains an assignment of benefits from the Insured Person. If such assignment is obtained, We will reimburse the Non-Network ambulance service directly for covered services.

- **Preventive Services:** Preventive Services shall be covered without regard to any Deductible, Copayment or Coinsurance requirement that would otherwise apply:
  a. 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, except that the current recommendations of the U.S. Preventive Services Task Force regarding breast cancer screening, mammography and preventive breast cancer shall be considered the most current other than those issued in or around November 2009.
  b. 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.
  c. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
  d. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph 1. as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

- **Home health care services**:
  a. As an alternative to otherwise covered services in a Hospital or related institution; and
  b. for Insured Persons who receive less than 48 hours of inpatient Hospitalization following removal of a testicle or removal of a testicle on an outpatient basis:
     (1) One home visit scheduled to occur within 24 hours after discharge from the Hospital or outpatient health care facility, and
     (2) An additional home visit if prescribed by the Insured Person's attending Physician.

- **Hospice care services** - We will pay the expenses incurred for Hospice care which includes the following items and services provided to a terminally ill Insured Person by, or by others under arrangements made by, a hospice program under a written plan (for providing such care to such individual) established and periodically reviewed by the individual's attending Physician and by the medical director of the program:
  a. nursing care provided by or under the supervision of a registered professional nurse,
  b. physical or occupational therapy, or speech-language pathology services,
  c. medical social services under the direction of a physician,
  d. services of a home health aide who has successfully completed a training program approved by the Secretary and
  e. homemaker services,
  f. medical supplies (including drugs and biologicals) and the use of medical appliances, while under such a plan,
  g. Physicians' services,
  h. short-term inpatient care (including both respite care and procedures necessary for pain control and acute and chronic symptom management) in an inpatient facility meeting such conditions as the Secretary determines to be appropriate to provide such care, but such respite care may be provided only on an intermittent, non-routine, and occasional basis and may not be provided consecutively over longer than five days,
  i. Family Counseling (including dietary counseling) with respect to care of the terminally ill individual and adjustment to his or her death, and
  j. any other item or service which is specified in the plan.

- **Durable medical equipment**, including nebulizers, peak flow meters, prosthetic devices such as leg, arm, back, or neck braces, artificial legs, arms, or eyes, and the training necessary to use these prostheses. We also cover hair prosthesis for hair loss that results from chemotherapy or radiation treatment for cancer if prescribed by the oncologist in attendance. We will provide coverage for one hair prosthetic.

- **Outpatient laboratory and diagnostic services** including but not limited to X-ray services and laboratory procedures.

- **Habilitative Services for Adults over age 19** – We cover Habilitative Services, as defined in the Definitions Section, provided to covered adults over age 19. Benefits are payable as shown in the Schedule of Benefits.

- **Rehabilitative Services** – We cover rehabilitative services. Benefits are payable as shown in the Schedule of Benefits.

- **Chiropractic services** up to 20 visits per condition per Policy Year.

- **Skilled Nursing Facility** services as an alternative to medically necessary inpatient Hospital services up to a maximum of 100 days per year.

- **Infertility Services** on the same basis as benefits provided for other pregnancy-related procedures for:
  a. Diagnosis and treatment of infertility;
  b. In vitro fertilization if:
     (1) The patient is an Insured Person;
     (2) For a patient whose spouse is of the opposite sex, the patient's oocytes are fertilized with the patient's spouse's sperm;

(3) The patient and the patient's spouse have a history of involuntary infertility which may be demonstrated by a history of:
   a) the patient and the patient's spouse are of opposite sexes and intercourse of at least 2 years' duration has failed to result in pregnancy; or
   b) the patient and the patient's spouse are of the same sex and six attempts of artificial insemination over the course of 2 years has failed to result in pregnancy; or
   c) The infertility is associated with any of the following medical conditions:
      1) Endometriosis;
      2) Exposure in utero to diethylstilbestrol (DES);
      3) Blockage of, or surgical removal of, one or both fallopian tubes; or
      4) Abnormal male factors, including oligospermia, contributing to the infertility

(4) The patient has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the Policy;

(5) The in vitro fertilization procedures are performed at medical facilities that conform to applicable guidelines issued by the American College of Obstetricians and Gynecologists or the American Society for Reproductive Medicine.

We will pay for up to three in vitro fertilization attempts per live birth.

- **Nutritional Counseling and Therapy** for an insured person who is at risk because of nutritional history, current dietary intake, medication use, or chronic illness or condition by a health care practitioner acting within the scope of his or her license:
  - cardiovascular disease;
  - diabetes, malnutrition;
  - cancer;
  - cerebral vascular disease;
  - or kidney disease.

- **Transplants** of Medically Necessary solid and non-solid organ transplant procedures on an Insured Person when performed by a Physician who is performing the transplant that is within his or her lawful scope of practice. Covered services include the cost of hotel lodging and air transportation to and from the site of the transplant for the recipient individual and a companion (or recipient individual and two companions if the recipient individual is under 18 years of age).

- **Medical food** for Insured Persons with metabolic disorders when ordered by a health care practitioner qualified to provide diagnosis and treatment in the field of metabolic disorders.

- **Family planning services**, including:
  a. Prescription contraceptive drugs or devices,
  b. Coverage for the insertion or removal of contraceptive devices,
  c. Medically necessary examination associated with the use of contraceptive drugs or devices, and
  d. Voluntary sterilization.

- **Habilitative Services for Children ages 0-19** for services, as defined in the Definitions Section. Benefits are payable as shown in the Schedule of Benefits. Except for Habilitative Services provided in early intervention and school services, **habilitative services** for children 0-19 years old include the treatment of Congenital or Genetic Birth Defects services for cleft lip and cleft palate, orthodontics, oral surgery, otologic, audiological, and speech therapy, physical therapy, and occupational therapy for children 0 — 19 years old for treatment of congenital or genetic birth defects.

- **Pregnancy and maternity services**, including abortion. We will pay the expenses incurred for maternity charges as follows:
  a. **Hospital stays** for mother and newly born child will be covered the same as for any other Covered Sickness. Minimum stays for uncomplicated births are described in the Schedule of Benefits. Whenever a mother is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the hospital, the Policy shall pay the cost of additional hospitalization for the newborn for up to 4 days. 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. Home visits related to maternity or newborn baby care are not subject to Deductibles, Copayments or Coinsurance.

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 visits. Any home visit must:
      i. Be provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;
      ii. Be provided by a registered nurse with at least 1 year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and
      iii. Include any services required by the attending Physician.
   (7) For a mother and newborn child who have a shorter hospital stay than that provided under item a of this benefit, We shall provide coverage for:
      i. one home visit scheduled to occur within 24 hours after Hospital discharge; and
      ii. an additional home visit if prescribed by the attending provider.

   For a mother and newborn child who remain in the hospital for at least the length of time provided under item a of this benefit, We shall provide coverage for a home visit if prescribed by the attending provider.

d. **Outpatient Physician's visits** will be covered the same as for any other Covered Sickness.

e. **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:
   (1) Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   (2) Inpatient Physician visits for routine examinations and evaluations;
   (3) Charges made by a Physician in connection with a circumcision;
   (4) Routine laboratory tests;
   (5) Postpartum home visits prescribed for a newborn; and
   (6) Follow-up office visits for the newborn subsequent to discharge from a Hospital.

- **Prescription drugs** 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 insulin as prescribed by a Physician. An Insured Person may receive up to a 90-day supply of a maintenance drug in a single dispensing of an authorized prescription with a proportional increase in the Copayment. A maintenance drug means a drug anticipated to be required for 6 months or longer to treat a chronic condition. If a prescription drug or device is not in the Formulary, We will cover the prescription drug or device as if in the Formulary if, in the judgment of the authorized prescriber:
  a. there is no equivalent prescription drug or device in Our Formulary; or
  b. an equivalent prescription drug or device in Our Formulary has been ineffective in treating the disease or condition of the Insured Person or has caused or is likely to cause an adverse reaction or other harm to the Insured Person.

  Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug for a treatment other than those treatments stated in the labeling approved by the federal Food and Drug Administration if the drug is recognized for treatment in any of the standard reference compendia or in the Medical Literature. Coverage of an off-label drug includes Medically Necessary services associated with

the administration of the drug. This benefit does not cover:
a. drugs that have not been approved by the federal Food and Drug Administration;
b. a drug if the federal Food and Drug Administration has determined use of the drug to be contraindicated; or
c. experimental drugs not approved for any indication by the federal Food and Drug Administration.

**Medical Literature** means scientific studies published in a peer-reviewed national professional medical journal.

**Standard Reference Compendia** means any authoritative compendia as recognized periodically by the federal Secretary of Health and Human Services or the Commissioner.

Specialty Drugs - "Specialty Drugs" are Prescription Drugs which:
a. Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or
b. 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.

Prescription Eye Drops - If prescription eye drops are otherwise covered under the Policy, We will pay for a refill of prescription eye drops:
a. in accordance with guidance for early refills of topical ophthalmic products provided to Medicare Part D plan sponsors by the Centers for Medicare and Medicaid Services; and
b. if the prescribing Physician indicates on the original prescription that additional quantities of the prescription eye drops are needed and the refill requested by the Insured Person does not exceed the number of additional quantities indicated on the original prescription by the prescribing health care Physician.

We may not impose a Copayment or Coinsurance requirement for a covered prescription drug or device that exceeds the retail price of the prescription drug or device.

- **Routine Patient Costs for an Approved Clinical Trial** for an Insured Person who is a Qualified Person.

- **Diabetes treatment, equipment, and supplies** - diabetes equipment includes glucose monitoring equipment under the durable medical equipment coverage for insulin-using beneficiaries. Diabetes supplies include coverage for insulin pumps, syringes and needles and testing strips for glucose monitoring equipment under the prescription coverage for insulin-using beneficiaries.

- **Mastectomy and Reconstructive Breast Surgery** as follows:
  a. Inpatient hospitalization services for an Insured Person for a minimum of 48 hours following a mastectomy. The Insured Person may request a shorter length of stay if she decides, in consultation with her Physician, that less time is needed for recovery. If an Insured Person receives less than 48 hours of inpatient hospitalization following a mastectomy or who undergoes a mastectomy on an outpatient basis, We will cover one (1) one home visit scheduled to occur within 24 hours after discharge from the hospital or outpatient health care facility and an additional home visit if prescribed by the Insured Person's Physician. If an Insured Person remains in the Hospital for at least 48 hours following a mastectomy, We will cover one (1) home visit if prescribed by the attending Physician. Benefits for home health care related to a mastectomy will be paid under this benefit and not the Home Health Care Benefit;
  b. Reconstructive breast surgery, including coverage for all stages of Reconstructive breast surgery performed on a nondiseased breast to establish symmetry with the diseased breast when Reconstructive breast surgery is performed on the diseased breast including augmentation mammoplasty, reduction mammoplasty, and mastopexy.
  c. Physical complications of all stages of Mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Insured Person.
  d. Prosthesis that has been prescribed by a Physician for an Insured Person who has undergone a mastectomy and has not had breast reconstruction.

- **General anesthesia and associated Hospital or ambulatory facility charges in conjunction with dental care** provided to the following:
  a. Insured Persons who are 7 years old or younger or developmentally disabled and for whom a:

(1) Successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured, and
(2) Superior result can be expected from dental care provided under general anesthesia;

b. Insured Persons 17 years old or younger who:
(1) Are extremely uncooperative, fearful, or uncommunicative,
(2) Have dental needs of such magnitude that treatment should not be delayed or deferred, and
(3) Are individuals for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

We may restrict general anesthesia and associated hospital coverage for dental care to care for which general anesthesia is required and that is provided by a:
a. Fully accredited specialist in pediatric dentistry,
b. Fully accredited specialist in oral and maxillofacial surgery, and
c. Dentist to whom Hospital privileges have been granted.

- **Hearing Aids Benefit** - for Insured Persons ages 0 to 18 years of age.

- **Treatment of Morbid Obesity -** surgical treatment of Morbid Obesity that is recognized by the National Institutes of Health as effective for the long-term reversal of Morbid Obesity and consistent with guidelines approved by the National Institute of Health.

- **Wellness Benefits** which include
  a. A health risk assessment that is completed by each Insured Person on a voluntary basis; and
  b. Written feedback to the Insured Person who completes a health risk assessment, with recommendations for lowering risks identified in the completed health risk assessment.
- **Pediatric Dental Benefits**

  Pediatric Dental Care - We Cover the following dental care services for covered Children up to age 19

  Emergency Dental Care: We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

  Preventive Dental Care: We cover dental preventive care which includes a preventive dental visit, screening, oral examination, teeth cleaning (prophylaxis), fluoride treatment, and routine preventive service. We shall provide coverage for dental preventive care:
  a. at any time during the Policy year for dental preventive care once during the Policy Year; or
  b. in accordance with any frequency limitation for dental preventive care more than once during the Policy Year as described below. We may not impose a frequency limitation on dental preventive care that requires the dental preventive care to be provided at an interval greater than 120 days during a Policy Year.

  Routine Dental Care: routine dental care provided in the office of a dentist according to the periodicity schedule developed by the American Academy of Pediatric Dentistry, as updated, including:
  a. Dental examinations, visits and consultations twice per year;
  b. X-ray, full mouth x-rays at thirty-six (36) month intervals per physician, bitewing x-rays at six (6) intervals per Physician, or panoramic x-rays at thirty-six (36) month intervals per Physician, and other x-rays if Medically Necessary;
  c. Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
  d. In-office conscious sedation;
  e. Amalgam, composite restorations and stainless steel crowns; and
  f. Other restorative materials appropriate for children.

  Benefits also include maxillofacial prosthetics, fixed prosthodontics, and adjunctive general services.

  Endodontic Services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

Periodontal Services, as described in the Schedule of Benefits, including scaling and root planing, debridement, maintenance, and periodontal surgery.

Prosthodontics Services as follows:
a. Removable complete or partial dentures dentures one per 60 months per Insured Person while covered; and
b. Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:
a. For replacement of a single upper anterior (central/lateral incisor or cuspid) in a covered Child with an otherwise full complement of natural, functional and/or restored teeth;
b. For cleft palate stabilization; or
c. Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

Care related to Prosthodontics Services must occur after six months of the initial service.

Orthodontics used to help restore oral structures to health and function and to treat a severe, dysfunctional, handicapping malocclusion such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.
Benefits for athletic mouth guards and occlusal guards are included, as shown in the Schedule of Benefits.

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

- **Pediatric Vision Benefits** for covered Children up to age 19.
  a. One routine eye exam, including dilation if professionally indicated, each year.
  b. One pair of prescription eyeglass lenses each year.
  c. One eyeglass frame each year.
  d. In lieu of eyeglasses, one pair of contact lenses each year.
  e. Low vision services, including one comprehensive low vision evaluation every 5 years, 4 follow-up visits in any 5-year period, and prescribed optical devices such as high-power spectacles, magnifiers and telescopes.

- **Cardiac Rehabilitation Benefit** - We will pay Cardiac Rehabilitation benefits for an Insured Person who has been diagnosed with significant cardiac disease, or has suffered a myocardial infarction, or who has undergone invasive cardiac treatment immediately preceding referral for Cardiac Rehabilitation. Services must be provided at a place of service equipped and approved to provide Cardiac Rehabilitation. We will pay the charges incurred for an Insured Person for:
  a. Continuous EKG telemetric monitoring during exercise, EKG rhythm strip with interpretation, Physician's revision of exercise prescription, and follow up examination for Physician to adjust medication or change regimen; and
  b. For coverage Adults over age 19, up to 90 days each of physical therapy, speech therapy and occupational therapy per contract year for Cardiac Rehabilitation. (These therapy benefits for Cardiac Rehabilitation are paid in addition to any benefits payable under the Rehabilitative Therapy Benefit for Adults over Age 19. There is no limit on visits for Children Ages 0-19.)

  The following exclusion applies to this benefit: Benefits will not be provided for maintenance programs. Maintenance programs consist of activities that preserve the individual's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals established by the Physician for the Insured Person have been achieved, or when no additional progress is apparent or expected to occur.

Cardiac Rehabilitation is a comprehensive program involving medical evaluation, prescribed exercise, cardiac risk factor modification, education and counseling.

- **Pulmonary Rehabilitation Benefit –** If an Insured Person is diagnosed with significant pulmonary disease, We will pay the charges for one pulmonary rehabilitation program during that Insured Person's lifetime. Services must be provided at a place of service equipped and approved to provide pulmonary rehabilitation.

- **Patient Centered Medical Homes Benefit –** We will pay the charges for the delivery of benefits through Patient Centered Medical Homes (PCMH) for Insured Persons with chronic conditions, serious illnesses or complex health care needs who agree to participate in a PCMH program. Benefits include associated costs for coordination of care, such as: Liaison services between the Insured Person and the health care provider, nurse coordinator, and the care coordination team; Creation and supervision of a care plan; Education of the individual and family regarding the Insured Person's disease, treatment compliance and self-care techniques; and Assistance with coordination of care, including arranging consultations with specialists and obtaining supplies and services deemed medically necessary by the Insured Person's Physician, including community resources.

  Patient Centered Medical Homes (PCMH) is a model of practice in which a team of health professionals, guided by a primary care provider, provides continuous, comprehensive, and coordinated care in a culturally and linguistically sensitive manner to patients throughout their lives. The PCMH provides for all of a patient's health care needs, or collaborates with other qualified professionals to meet those needs. PCMH is coordinated by the Maryland Health Care Commission.

  **Mental Health Disorder and Substance Use Disorder Benefit** for diagnosis and treatment of Mental Health Disorders and Substance Use Disorders. Eligible services include:

  1. Professional services provided by a licensed professional mental health and substance use practitioner, acting within the scope of his or her license, such as a psychiatrist, psychologist, clinical social worker, licensed professional counselor, or marriage and family therapist. Benefits will be paid on the same basis as any other Covered Sickness for the following Mental Health Disorder and Substance Use Disorder diagnosis and treatment services:
     a. Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:
        1) Diagnostic evaluation;
        2) Crisis intervention and stabilization for acute episodes;
        3) Medication evaluation and management (pharmacotherapy);
        4) Treatment and counseling (including individual or group therapy visits)
        5) Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling;
        6) Professional charges for intensive outpatient treatment in a provider's office or other professional setting.
     b. Electroconvulsive therapy;
     c. Inpatient professional fees;
     d. Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner;
     e. Outpatient diagnostic tests provided and billed by a laboratory, hospital, or other covered facility;
     f. Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment.
  2. Inpatient hospital and inpatient residential treatment centers services, which include:
     a. Room and board, such as:
        1) Ward, semiprivate, or intensive care accommodations. Private room is covered only if medically necessary. If private room is not medically necessary, we will only cover the hospital's average charge for semiprivate accommodations;
        2) General nursing care;
        3) Meals and special diets.
     b. Other facility services and supplies – services provided by a hospital or residential treatment center.
  3. Outpatient hospital – services such as partial hospitalization or intensive day treatment programs in any authorized facility.
  4. Emergency room – outpatient services and supplies billed by a hospital for emergency room treatment.

**Additional Optional 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.

  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, subject to the Extension of Benefits provision,
  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 or more consecutive 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. (**Note:** if this Policy replaces a Student Group Health Insurance Policy with a different insurer that has authorized a medical evacuation, We will honor that authorization under this Policy.);
  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 12 months 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.

**Accidental Injury Dental Treatment for Insured Persons over age 18 –** As a result of injury. Routine dental care and treatment are not payable under this benefit.

**ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

If, as the result of a covered Accident, an Insured Person sustains any of the following losses within the time shown in the Schedule of Benefits, We will pay the benefit shown.

Loss of Life ..... The Principal Sum
Loss of hand ..... One-Half the Principal Sum
Loss of Foot ..... One-Half the Principal Sum
Loss of either one hand, one foot or sight of one eye ..... One-half the Principal Sum
Loss of more than one of the above losses due to one Accident ..... The Principal Sum

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

Extension of Benefits: We will pay the benefit described herein for a covered loss that occurs after the date coverage terminates if:

1. an Accident occurs while the individual is covered; and
2. the loss described above occurs within 90 days after the Accident.

**Section 4 – Exclusions and Limitations**

**Exclusion Disclaimer**: Any exclusion in conflict with the Patient Protection and Affordable Care Act will be administered to comply with the requirements of the Act.

The following are exclusions and limitations to the covered services:

1. Services that are not Medically Necessary, including Elective Surgery and Elective Treatment;
2. Services performed or prescribed under the direction of a person who is not a Physician;
3. Services that are beyond the scope of practice of the Physician performing the service;
4. Services to the extent they are covered by any government unit, except for veterans in Veterans' Administration or armed forces facilities for services received for which the recipient is liable;
5. Services for which a Insured Person is not legally, or as a customary practice, required to pay in the absence of a health benefit plan;
6. The purchase, examination, or fitting of eyeglasses or contact lenses, except for aphakic patients and soft or rigid gas permeable lenses or sclera shells intended for use in the treatment of a disease or injury or if otherwise covered under the Pediatric Vision benefit;
7. Personal care services and domiciliary care services;
8. Services rendered by a Physician who is a Insured Person's spouse, mother, father, daughter, son, brother, or sister;
9. Experimental services;
10. Practitioner, hospital, or clinical services related to radial keratotomy, myopic keratomileusis, and surgery which involves corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error;
11. Ovum transplants and gamete intrafallopian tube transfer, zygote intrafallopian transfer, or cryogenic or other preservation techniques used in these or similar procedures, unless otherwise specified in Covered Services.
12. Services to reverse a voluntary sterilization procedure;
13. Services for sterilization or reverse sterilization for a dependent minor, unless the sterilization is an FDA approved sterilization procedure for women with reproductive capacity;
14. Medical or surgical treatment or regimen for reducing or controlling weight, unless otherwise specified in the covered services;
15. Services incurred before the effective date of coverage for a Insured Person;
16. Services incurred after a Insured Person's termination of coverage, including any extension of benefits;
17. Surgery or related services that is not Medically Necessary for cosmetic purposes to improve appearance, but not to restore bodily function or correct deformity resulting from disease, trauma, or congenital or developmental anomalies;
18. Services for injuries or diseases related to an Insured Person's job to the extent the Insured Person is required to be covered by a workers' compensation law;

19. Services rendered from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust, or similar persons or groups;
20. Personal hygiene and convenience items, including, but not limited to, air conditioners, humidifiers, or physical fitness equipment;
21. Charges for telephone consultations, failure to keep a scheduled visit, or completion of any form;
22. Inpatient admissions primarily for diagnostic studies;
23. The purchase, examination, or fitting of hearing aids and supplies, and tinnitus maskers, except as required as a covered service;
24. Except for Emergency Services and services required under the Organ Transplant Benefit, services received while the Insured Person is outside the United States, except as otherwise covered under the Policy;
25. Immunizations related to foreign travel;
26. Unless otherwise specified in covered services, dental work or treatment which includes hospital or professional care in connection with:
    a. The operation or treatment for the fitting or wearing of dentures,
    b. Orthodontic care or malocclusion,
    c. Operations on or for treatment of or to the teeth or supporting tissues of the teeth, except for removal of tumors and cysts or treatment of injury to natural teeth due to an accident if the treatment is received within 6 months of the accident; and
    d. Dental implants;
27. Accidents occurring while and as a result of chewing except as otherwise covered under the Pediatric Dental Services Benefit;
28. Routine foot care, including the paring or removing of corns and calluses, or trimming of nails, unless these services are determined to be Medically Necessary;
29. Arch support, orthotic devices, in-shoe supports, orthopedic shoes, elastic supports, or exams for their prescription or fitting, unless these services are determined to be Medically Necessary;
30. Inpatient admissions primarily for physical therapy;
31. Treatment leading to or in connection with transsexualism, or sex changes or modifications, including but not limited to surgery;
32. Treatment of sexual dysfunction not related to organic disease;
33. Services that duplicate benefits provided under federal, State, or local laws, regulations, or programs;
34. Nonhuman organs and their implantation;
35. Nonreplacement fees for blood and blood products;
36. Lifestyle improvements, including nutrition counseling, or physical fitness programs, unless included as a covered service;
37. Wigs or cranial prosthesis unless included as a covered service because of hair loss due to chemotherapy or radiation treatment for cancer;
38. Weekend admission charges, except for emergencies and maternity;
39. Out-patient orthomolecular therapy, including nutrients, vitamins, and food supplements;
40. Temporomandibular joint syndrome (TMJ) treatment and treatment for craniomandibular pain syndrome (CPS), except for surgical services for TMJ and CPS, if Medically Necessary and if there is a clearly demonstrable radiographic evidence of joint abnormality due to disease or injury;
41. Services resulting from accidental bodily injuries arising out of a motor vehicle accident to the extent the services are payable under a medical expense payment provision of an automobile insurance policy;
42. Services for conditions that State or local laws, regulations, ordinances, or similar provisions require to be provided in a public institution;
43. Services for, or related to, the removal of an organ from a Insured Person for purposes of transplantation into another person, unless the:
    a. Transplant recipient is covered under the plan and is undergoing a covered transplant, and
    b. Services are not payable by another carrier;
44. Physical examinations required for obtaining or continuing employment, insurance, or government licensing;
45. Nonmedical ancillary services such as vocational rehabilitation, employment counseling, or educational therapy;
46. Private hospital room; or
47. Private duty nursing.

48. In addition, for International Students only, the following are not covered services:
    a. expenses incurred within the Insured Person's Home Country or country of regular domicile; and
    b. Eligible expenses within the Insured Person's Home County or country of origin that would be payable or medical treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
49. The following services are excluded from the Mental Health Disorder and Substance Use Disorder benefit:
    a. services provided by pastoral or marital counselors;
    b. therapy for sexual problems;
    c. treatment for learning and intellectual disabilities;
    d. telephone therapy;
    e. Travel time to the Insured Person's home to conduct therapy;
    f. Marriage counseling; and
    g. Services that are not medically necessary.

**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. Our recovery amount will be reduced by Our share or the Insured Person's court cost and attorney's fees. Our share of the Insured Person's court cost and attorney fees will be a pro rata amount based on Our portion of the total third-party payment. Our share of the court and attorney fees will not exceed one-third of those costs.

The Insured Person must complete and return the required forms to us.

**Section 5 - CERTIFICATE PROVISIONS**

**Contestability of Coverage**: The Insured Person's coverage may not be contested, except for nonpayment of premiums, after it has been in force for 2 years from its date of issue. A statement made by any Insured Person relating to insurability may not be used in contesting the validity of the insurance with respect to which the statement was made after the insurance has been in force before the contest for a period of 2 years during the Insured Person's lifetime. Absent fraud, each statement made by an Insured Person is considered to be a representation and not a warranty. A statement made to effectuate insurance may not be used to avoid the insurance or reduce benefits under the Policy unless:

1. The statement is contained in a written instrument signed by the group policyholder or insured, and
2. A copy of the statement is given to the group policyholder, insured, or beneficiary of the insured.

**Notice of Claim:** Written notice of a claim is not required before 20 days after the occurrence or commencement of the loss covered by the Policy. We will not invalidate or reduce a claim if it is shown that It was not reasonably possible to give notice within 20 days and notice was given as soon as was reasonably possible.

**Claim Forms:** 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 after notice of claim is received, 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.

**Proof of Loss:** Written proof of Loss must be furnished to Us or to our authorized agent within 90 days after the date of such Loss. Failure to furnish the proof of loss within the time required does not invalidate or reduce a claim if it was not reasonably possible to submit the proof within the required time, if the proof is furnished as soon as reasonably possible and, except in the absence of legal capacity of the claimant, not later than 1 year from the time proof is otherwise required.

**Time of Payment:** Indemnities payable under this Policy will be paid within 30 days upon receipt of due proof of such Loss.

**Payment of Claims:** 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 $5,000.00, 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 the Department of Health and Mental Hygiene notifies Us that the Department has paid for or provided services to an Insured Person who is covered under this Policy, We shall reimburse the Department for the cost of the services, regardless of the above. The benefits payable to the Department are limited to those benefits available under the terms and conditions of this Policy for the services paid for or provided by the Department. We are not required to make payment to the Department if, before receiving notice from the Department, We have paid the benefits available under this Policy in good faith and in accordance with the terms and conditions of this Policy. Notwithstanding any other provision of this Policy, We may not refuse to reimburse the Department because of the manner, form, or date for reimbursement if, within 2 years after the date of the service for which reimbursement is sought, the Department provides to Us sufficient information to determine Our liability.
**Physical Examination and Autopsy:** We will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of death of an Insured Person, We may have an autopsy performed unless prohibited by law. The physical examination or autopsy will be performed at Our expense.
**Misstatement of Age:** If the age of an Insured Person has been misstated, an adjustment of premiums shall be made based on the Insured Person's true age. If age is a factor in determining eligibility or amount of insurance and there has been a misstatement of age, the insurance coverages or amounts of benefits, or both, shall be adjusted in accordance with the Insured Person's true age. Any such misstatement of age shall neither continue insurance otherwise validly terminated nor terminate insurance otherwise validly in force.
**Legal Actions:** No action at law or in equity will be brought to recover on this Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.
**Conformity with State Statutes:** Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.
**Assignment:** Any portion of any benefits payable for Hospital, nursing, medical or surgical services may, at the Insured Person's option, be paid directly to such Hospital or provider of the service upon authorization by the Insured Person. We do not assume any responsibility for the validity of assignment.

**Complaints:** To file a complaint with the Maryland Insurance Administration, gather the following items:
1. Your name, address, daytime and evening phone number;
2. Name of the insurance carrier, type of insurance (life, health, etc.) policy number and claim number (if applicable);
3. Name of any other insurance carrier, adjuster, etc., involved in the issue;
4. A detailed explanation of the situation;
5. Copies (do not send originals)of documentation that are important for the investigator to review;
6. A copy of the health insurance policy or certificate;
7. If the complaint pertains to a denial of health care services, include a medical records release form (available through the Maryland Insurance Administration's web site).

Mail or fax the information listed above to:

Maryland Insurance Administration
Attention: Consumer Complaint Investigation – Health Insurance
200 St. Paul Place, Suite 2700
Baltimore, MD 21202
Phone: 410-468-2000 or 1-800-492-6116
TTY: 1-800-735-2258
Fax: 410-468-2270 or 410-468-2260

**Section 6 – Coordination of Benefits**

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

**Definitions:**

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.
   (1) Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.
   (2) Plan does not include: intensive care policy, specified disease policy, hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; supplemental coverage as described in state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans unless permitted by law, or personal injury protection under a motor vehicle liability policy.

Each Policy for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. This plan means, in a COB provision, the part of the Policy providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the Policy providing health care benefits is separate from this plan. A Policy may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

D. Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging an Insured Person is not an Allowable expense.

   The following are examples of expenses that are not Allowable expenses: 1. The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses. 2. If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense. 3. If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense. 4. If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits. 5. The amount of any benefit reduction by the Primary plan because an Insured Person has failed

to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

E. Closed panel plan is a Plan that provides health care benefits to Insured Persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

**Order of Benefit Determination Rules:** When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows: A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan. B. If the Primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the Secondary plan shall pay or provide benefits as if it were the Primary plan when an Insured Person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the Primary plan. C. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary. (2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policy holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits. C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan. D. If a person is covered by more than one Secondary plan, the order of benefit determination rules described herein decide the order in which Secondary plan benefits are determined in relation to each other. Each Secondary plan shall take into consideration the benefits of the Primary plan or plans and the benefits of any other plan which, under the rules of the COB provision has its benefits determined before those of the Secondary plan. E. Each Plan determines its order of benefits using the first of the following rules that apply: (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan. (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows: a. For a dependent child whose parents are married or are living together, whether or not they have ever been married: i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or ii.. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan. However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan. b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married: i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree; ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits; iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows: • The Plan covering the Custodial parent; • The Plan covering the spouse of the Custodial parent; • The Plan covering the non-custodial parent; and then • The Plan covering the spouse of the non-custodial parent. c. For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph a. or b. above shall determine the order of benefits as if those individuals were the parents of the child. d. For a dependent child who has coverage under one or both parents and who is also a dependent Spouse, the plan that covered dependent child for the longer period of time is the Primary Plan. The plan that covered the dependent for the shortest period of time is the secondary plan. e. In the event that the dependent's coverage under the Spouse's plan began on the same date as

the dependent's coverage under either or both plans, the order of benefits will be determined by applying the birthday rule described in item E.(2) above. (3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits. (4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits. (5) Longer or shorter length of coverage. If the preceding rules do not determine the order of benefits, the Plan that covered the person for the longer period of time is the Primary plan and the Plan that covered the person for the shorter period of time is the Secondary plan. To determine the length of time a person has been covered under the Plan, two successive Plans shall be treated as one if the Insured Person was eligible under the second Plan within 24 hours after coverage under the first Plan ended. The start of the new Plan does not include: a. A change in the amount or scope of the Plan's benefits; b. A change in the entity that pays, provides or administers the Plan's benefits; or c, A change from one type of Plan to another, such as, from a single employer to a multiple employer.

The Insured Person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This plan will not pay more than it would have paid had it been the Primary plan.

**Effect on the Benefits of This Plan:** A. When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

B. If an Insured Person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

**Right to Receive and Release Needed Information:** Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Our Agent or We may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. Our Agent or We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give Our Agent or We any facts it needs to apply those rules and determine benefits payable.

**Facility of Payment:** A payment made under another Plan may include an amount that should have been paid under This plan. If it does, Our Agent or We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. Our Agent or We will not have to pay that amount again. The term payment made includes providing benefits in the form of services, in which case payment made means the reasonable cash value of the benefits provided in the form of services.

**Right of Recovery:** If the amount of the payments made by Our Agent or We is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid, or any other person or organization that may be responsible for the benefits or services provided for the Insured Person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

**Servicing Agent:**
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
Telephone (800) 437-6448
www.univsityhealthplans.com
or email us at info@universityhealthplans.com

Underwritten by:
National Guardian Life Insurance Company
as policy form # NBH-280(2015) MD

Administered by:
Claims Administrator:
CONSOLIDATED HEALTH PLANS
2077 Roosevelt Avenue
Springfield, MA 01104
Toll Free (877) 657-5030
www.chpstudent.com
Group Number: ST0973SH

**For a copy of the Company's privacy notice you may:**
go to
www.chpstudent.com
or
***Request one from the Health office at your school***
*or*
***Request one from:***
**National Guardian Life Insurance Company**
C/O Privacy Officer
70 Genesee Street
Utica, NY 13502
**(Please indicate the school you attend with your written request.)**

**CLAIM PROCEDURE**

In the event of an Injury or Sickness:

1. A claim form is not required to submit a claim. However, an itemized bill, HCFA 1500, or UB92 form should be used to submit expenses. If a referral was required, this form should accompany this submission. The Insured Student/Person's name and identification number need to be included.
2. Providers should submit claims within 180 days from the date of Injury or from the date of the first medical treatment for a Sickness, or as soon as reasonably possible. If a student is submitting the claim, a copy should be retained and claims should be mailed to:

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

1. Submit only one claim form for each Accident or Sickness

**Representations of this plan must be approved by Us.**

**Important**

**THIS CERTIFICATE IS INTENDED ONLY FOR A QUICK REFERENCE AND DOES NOT LIMIT OR AMPLIFY THE COVERAGE DESCRIBED IN THE MASTER POLICY WHICH CONTAINS THE COMPLETE TERMS AND PROVISIONS. THE MASTER POLICY IS ON FILE WITH 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 Plan Underwritten by National Guardian Life Insurance Company. These value added options are provided by Consolidated Health Plans.

**EMERGENCY MEDICAL AND TRAVEL ASSISTANCE**

Consolidated Health Plans provides access to a comprehensive program that will arrange emergency medical and travel assistance services, repatriation services and other travel assistance services when you are traveling. For general inquiries regarding the travel access assistance services coverage, please call Consolidated Health Plans at 1-800-633-7867. **If you are traveling and need assistance in North America, call the Assistance Center toll-free at: 877.305.1966 *or* if you are in a foreign country, call collect at: 715.295.9311**. When you call, please provide your name, school name, the group number shown on your ID card, and a description of your situation. If the condition is an emergency, you should go immediately to the nearest physician or hospital without delay and then contact the 24-hour Assistance Center.

**VISION DISCOUNT PROGRAM**

A Vision Discount Program is available to students enrolled in the Washington 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.

Cigna.

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 toll-free at (877) 657-5030, or www.chpstudent.com for assistance.