Student Health Insurance Program

Designed for the Students of

Worcester Academy

Worcester, Massachusetts

2015-2016

National Guardian Life Insurance Company

Madison, WI

Policy Number: 2015I5A93

Effective: August 1, 2015 to July 31, 2016

Group Number: S210906

NOTICE: Be advised that you may be eligible for coverage under your parents' plan if you are under the age of 26. If you have any questions or concerns about this notice, contact Consolidated Health Plans, 800-633-7867.

IMPORTANT NOTICE

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

NONDISCRIMINATORY

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

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

BENEFITS UNDER THIS CERTIFICATE ARE LIMITED TO EXPENSES THAT ARE IN EXCESS OF BENEFITS PAYABLE UNDER OTHER VALID INSURANCE COVERAGE.

TRANSLATION SERVICES:

English/English

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

Español/Spanish

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

Русский/Russian

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

Français/French

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

Italiano/Italian

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

Português/Portuguese

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

Ελληνικά/Greek

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

中文/Chinese

當您打電話給客服中心時，可利用翻譯員的服務。在您要求之下，
我們會提供有關行政步驟過程的口譯以及翻譯服務。

Kreyl/Haitian Creole

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

ភាសាខ្មែរ /Khmer

អ្នកបកប្រែទាំងអស់ អាចបំរើលោកអ្នកបាន លុះត្រាតែលោកអ្នក ទូរស័ព្ទទៅលេខ សំរាប់ការបំរើអតិថិជន។ ពេលសំណើរ ត្រូវយើងទទួលរួចហើយ យើងនឹងផ្តល់ ការបំរើផ្នែកការបកប្រែ ទាំងការបកប្រែ ពីសំណេរ ក៏ដូចជា ការបកប្រែផ្ទាល់មាត់ ទៅតាម ទំរង់ការរបស់ទីចាត់ការរៀបចំ។

ລາວ/Lao

ຈະມີນາຍພາສາໃຫ້ຕົວລາທ່ານໃນເວລາທີ່ໂທຫານ້ຳເບີຂອງພະແນກຊ່ວຍເຫຼືອລູກຄ້າ. ພາຍຫຼັງການຂໍແລ້ວ ພວກເຮົາຈະໃຫ້ບໍລິການນາຍພາສາແປຄວາມເວົ້າແລະແປເອກະສານ ທີ່ກ່ຽວກັບການປະຕິບັດດ້ານບໍລິຫານຕ່າງໆ.

عربي/Arabic

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

STUDENT ELIGIBILITY AND ENROLLMENT

To be eligible for coverage You must:

1. meet the enrollment requirements stated in the Insurance Information Schedule; and
2. pay the required premium; and
3. attend classes for at least the first 31 days of the period for which premium has been paid, except in the case of medical withdrawal.

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

You may enroll in this Insurance Program only during the thirty-one (31) day periods beginning with the start of the first and second terms. If You are eligible for coverage and wish to enroll in the Program after these enrollment opportunities, You must present documentation from Your former insurance company that it is no longer providing You with personal accident and health insurance coverage. Your effective date under this Program will be the date Your former insurance expired, if You make the request for coverage within sixty (60) days after it expires. Otherwise, the effective date will be the first (1st) of the month following Your request. Your premium for this coverage must accompany the request.

MASSACHUSETTS REQUIREMENT TO PURCHASE HEALTH INSURANCE

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

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

THIS DOCUMENT IS FOR MINIMUM CREDITABLE COVERAGE STANDARDS THAT ARE EFFECTIVE JANUARY 1, 2009. BECAUSE THESE STANDARDS MAY CHANGE, REVIEW YOUR PLAN MATERIAL EACH YEAR TO DETERMINE WHETHER YOUR PLAN MEETS THE LATEST STANDARDS.

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

PREMIUM

The insurance under Worcester Academy Student Health Insurance Plan for the Annual Policy is effective 12:01 a.m. on August 1, 2015. The Annual Policy terminates at 11:59 p.m. on July 31, 2016 or at the end of the period through which the premiums are paid, whichever is earlier.

	Annual 8/1/2015-7/31/2016
Student	$1,110

The above rate include an administrative fee retained by the servicing agent.

REFUND OF PREMIUM

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

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

DEPENDENT ELIGIBILITY AND ENROLLMENT

A Dependent newborn child will be automatically covered under the Policy from the moment of birth until the thirty-first (31st) day following birth. During the thirty-one (31) day period, We must receive written notice of the birth and the required premium must be paid. Coverage for such newborn children will consist of coverage for Injury or Sickness including the necessary care and treatment of medically diagnosed congenital defects, birth abnormalities, or premature birth, including the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by the regulations of the Department of Public Health.

TERMINATION

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

- The Termination Date of the Policy for all Insured Persons; or
- The end of the period of coverage for which premium has been paid; or
- The date an Insured Person ceases to be eligible for the insurance; or
- The date a Insured Person enters military service.

On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error.

GENERAL DEFINITIONS

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

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

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.

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

Covered Injury means a bodily injury that is:

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

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

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

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

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

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

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

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

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

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

Elective Treatment includes, but is not limited to: treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to: circumcision, vasectomy, breast reduction, 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.

Hospital means an institution that:

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

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

Hospital does not include the following:

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

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

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

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

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

Medical Necessity or **Medically Necessary** means:

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

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

Physician means a:

1. Doctor of Medicine (M.D.); or
2. Doctor of Osteopathy (D.O.); or
3. Doctor of Dentistry (D.M.D. or D.D.S.); or
4. Doctor of Chiropractic (D.C.); or
5. Doctor of Optometry (O.D.); or
6. Doctor of Podiatry (D.P.M.);

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

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician. Physician also includes Christian Science Practitioners listed in the Christian Science Journal at the time the service is provided and who adheres to the rules and regulations of the First Church of Christ, Scientist, Boston, Massachusetts. The term Physician does not mean any person who is an Insured Person's spouse or the parent, child, brother or sister of the Insured Person or his or her spouse.

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

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

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

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

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

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

Usual and Reasonable means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a:

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

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

STUDENT HEALTH INSURANCE

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

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

SCHEDULE OF BENEFITS	
Preventive Services	Coinsurance and Deductible are not applicable to Preventive Services. Benefits are paid at 100% of U&R.
Deductible	$0
Out-of-Pocket Expense Limit:	$6,350
Coinsurance	100% of Covered Medical Expenses

Inpatient Benefits	
Hospital Room & Board Expenses	The Coinsurance Amount shown above
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	The Coinsurance Amount shown above
Hospital Miscellaneous Expenses for services & supplies	The Coinsurance Amount shown above
Preadmission Testing	The Coinsurance Amount shown above
Physician's Visits while Confined:	The Coinsurance Amount shown above; Visit limited to one per day of Confinement
Inpatient Surgery: • Surgeon Services • Anesthetist • Assistant Surgeon	The Coinsurance Amount shown above The Coinsurance Amount shown above The Coinsurance Amount shown above
Physical Therapy (inpatient)	The Coinsurance Amount shown above
Outpatient Benefits	
Outpatient Surgery: • Surgeon Services • Anesthetist • Assistant Surgeon	The Coinsurance Amount shown above The Coinsurance Amount shown above The Coinsurance Amount shown above
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	The Coinsurance Amount shown above
Outpatient Facility Fee	The Coinsurance Amount shown above
Short Term Rehabilitation Therapy (outpatient)	The Coinsurance Amount shown above
Emergency Services Expenses	The Coinsurance Amount shown above
Primary Care Visit to Treat an Injury or Illness (includes syringes and needles dispensed during a visit)	The Coinsurance Amount shown above per visit
Specialist Visit	The Coinsurance Amount shown above per visit
Other Practitioner Office Visit	The Coinsurance Amount shown above per visit
Urgent Care	The Coinsurance Amount shown above
Imaging Tests	The Coinsurance Amount shown above
Diagnostic X-ray Services	The Coinsurance Amount shown above

Laboratory Procedures (Outpatient)	The Coinsurance Amount shown above
Outpatient Prescription Drugs	The Coinsurance Amount shown above
Home Health Care Expenses	The Coinsurance Amount shown above
Hospice Care Coverage	The Coinsurance Amount shown above
Skilled Nursing Facility Benefit	The Coinsurance Amount Shown Above
Podiatry Care Benefit	The Coinsurance Amount Shown Above
TMJ Disorder Treatment	The Coinsurance Amount Shown Above
Dialysis Services Benefit	The Coinsurance Amount Shown Above
Other Benefits	
Ambulance Service - Ground and/or Air and/or water Transportation	The Coinsurance Amount shown above
Braces and Appliances	The Coinsurance Amount shown above
Durable Medical Equipment	The Coinsurance Amount shown above
Maternity Benefit	Same as any other Covered Sickness
Routine Newborn Care	Same as any other Covered Sickness.
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate, intramural or club sports	The Coinsurance Amount shown above
Medical Evacuation Expense - (International Students and/or their Dependents and Domestic Student participating in a study abroad program)	U&R, not to exceed $50,000.00
Repatriation Expense - (International Students and/or their Dependents and Domestic Student participating in a study abroad program)	U&R, not to exceed $50,000.00
Mandated Benefits	
Autism Spectrum Disorder Benefit	The Coinsurance Amount shown above
Cancer Treatment Benefit	The Coinsurance Amount shown above except as otherwise described in the benefit up to $500 per Policy Year for Scalp Hair Prosthesis
Cardiac Rehabilitation Benefit	The Coinsurance Amount shown above
Chiropractic Care Benefit	The Coinsurance Amount shown above
Cleft Palate and Cleft Lip Benefit	The Coinsurance Amount shown above
Cytologic Screening (pap smear) and Mammographic Examination	The Coinsurance Amount shown above
Diabetes Equipment, Supplies and Service Benefit	The Coinsurance Amount shown above

Early Intervention Services	The Coinsurance Amount shown above
Fitness Benefit	The Coinsurance Amount shown above up to $150 per Policy year
Hormone Replacement Therapy Services; Outpatient Contraceptive Services	The Coinsurance Amount shown above
Human Leukocyte Testing	The Coinsurance Amount shown above
Infertility Benefit	The Coinsurance Amount shown above
Mastectomy Surgery and Rehabilitation Benefit	The Coinsurance Amount shown above
Mental Illness Benefit	The Coinsurance Amount shown above up to the limits described in the Benefit
Morbid Obesity & Bariatric Surgery Benefit	The Coinsurance Amount shown above
Non-Prescription Enteral Formula and Low Protein Food Formulas	The Coinsurance Amount shown above up to a maximum of $5,000 per Policy Year
Organ Transplant Benefit	The Coinsurance Amount shown above
Oxygen and Respiratory Therapy Benefit (for home use)	The Coinsurance Amount shown above
Pediatric Dental Care Benefit	The Coinsurance Amount shown above
Pediatric Vision Care Benefit	The Coinsurance Amount shown above
Prosthetic Devices	The Coinsurance Amount shown above for Durable Medical Equipment up to $500 per Policy Year for Scalp Hair Prosthesis
Telemedicine Consultation Benefit	The Coinsurance Amount shown above
Treatment of Speech, Hearing (including Hearing Aid Purchase) and Language Disorders Benefit	The Coinsurance Amount shown above up to the limits shown in the Benefit.
Weight Loss Program Benefit	The Coinsurance Amount shown above up to $150 per Policy Year

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum for Double Dismemberment or Loss of Life……$10,000
½ Principal Sum for Single Dismemberment……$10,000
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.

INPATIENT BENEFITS

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

Hospital Room and Board Expense, including general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed. We will provide coverage for a private room charge when deemed Medically Necessary for an Insured Person. If a private room is used, the Insured Person must pay all costs that are greater than the semi-private room rate.

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

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

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

Preadmission Testing - We will pay the charges for routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital. These tests must be performed within 7 working days prior to admission. This benefit is limited to routine tests such as complete blood count, urinalysis, and chest x-rays. Unless otherwise payable under the policy, We will pay for major diagnostic procedures under the Hospital Miscellaneous Expense Benefit. This includes tests such as CAT scans, cardiac catheterization, MRI's, NMR's, and blood chemistries.

Physician's Visits while Confined – We will pay the expenses incurred for Physician's visits not to exceed one visit per day. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

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

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

OUTPATIENT BENEFITS

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

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

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

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

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

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

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

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

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

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

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

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

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

Laboratory Procedures (Outpatient) – We will provide coverage for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

Prescription Drugs -

a. We will pay the expenses incurred for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made. Benefits include hypodermic needles or syringes required for the administration of a prescription drug.
b. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
   i. The drug is approved by the FDA;
   ii. The drug is prescribed for the treatment of a life-threatening condition including but not limited to cancer or human immunodeficiency virus or acquired immunodeficiency syndrome (AIDS/HIV);
   iii. The drug has been recognized for treatment of that condition by one of the following:
      (a) The American Medical Association Drug Evaluations;
      (b) The American Hospital Formulary Service Drug Information.
      (c) The United State Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or
      (d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

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

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

disease is interrupted; or

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

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

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

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

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

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

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

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

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

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

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

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

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

As used in this benefit:

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

a. Individuals who have no reasonable prospect of cure as estimated by a Physician; and

b. The immediate families or family caregivers of those individuals.

Skilled Nursing Facility Benefit - We will the expenses incurred for items and services provided as an inpatient in a skilled nursing bed of Skilled Nursing Facility or hospital, including room and board in semi-private accommodations. This coverage includes rehabilitative services; and drugs, biologicals, and supplies furnished for use in the Skilled Nursing Facility and other medically necessary services and supplies. This coverage is limited to 100 days per Policy Year. Custodial or residential care in a Skilled Nursing Facility or any other facility is not covered except as rendered as part of Hospice Care.

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

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

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

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

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

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

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

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

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

Medical Evacuation Expense – If:

a. an Insured Person is unable to continue his or her academic program as the result of a Covered Injury or Covered Sickness;
b. that occurs while he or she is covered under this Policy, We will pay the necessary Usual and Reasonable charges for evacuation to another medical facility or the Insured Person's Home Country. Benefits will not exceed the specified benefit shown in the Schedule of Benefits.

Payment of this benefit is subject to the following conditions:

a. The Insured Person must have been in a Hospital due to a Covered Injury or Covered Sickness for a confinement of three (3) – ten (10) days immediately prior to medical evacuation;
b. Prior to the medical evacuation occurring, the attending Physician must have recommended and We must have approved the medical evacuation;
c. We must approve the Usual and Reasonable Expenses incurred prior to the medical evacuation occurring, if applicable;
d. No benefits are payable for Usual and Reasonable Expenses after the date the Insured Person's insurance terminates. However, if on the date of termination, the Insured Person is in the Hospital, this benefit continues in force until the earlier of the date the confinement ends or 31 days after the date of termination;
e. Evacuation of the Insured Person to his or her Home Country terminates any further insurance under the Policy for the Insured Person; and
f. Transportation must be by the most direct and economical route.

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

STATE MANDATED BENEFITS

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

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

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

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

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

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

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

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

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

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

2. Leukocyte Testing - We will pay the expenses incurred for the cost of human leukocyte antigen testing or histocompatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. This will include the costs of testing for A, B, or DR antigens or any combination thereof, consistent with rules, regulations and criteria established by the Department of Public Health.
3. Scalp Hair Prostheses - We will pay the expenses incurred for scalp hair prostheses worn for hair loss suffered as a result of the treatment of any form of cancer or leukemia. Such coverage will be subject to a written prescription from the treating Physician and will be subject to the same limitations and guidelines as any other prosthesis that would be covered by this Policy. The maximum benefit for Scalp Hair Prosthesis is $500 per policy year.
4. Clinical Trials for Cancer - We will pay the expenses incurred for Patient Care Services in connection with a qualified cancer clinical trial to the same extent as they would be covered and reimbursed if the Insured Person did not receive care in a Qualified Clinical Trial. Coverage for the services required under this benefit are provided subject to the terms and conditions generally applicable to other benefits provided under the Policy.
5. Orally Administered Cancer Medications – We will pay the Usual and Reasonable expense incurred for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells on the same basis as intravenously administered or injected cancer medications that are covered as medical benefits.
6. Radiation Therapy and Chemotherapy – We will pay the Usual and Reasonable expenses incurred for prescribed x-ray therapy and chemotherapy. This coverage includes:
    - Radiation therapy using isotopes, radium, radon, or other ionizing radiation.
    - X-ray therapy for cancer or when it is used in place of surgery.
    - Drug therapy for cancer (chemotherapy).

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

1. An investigational drug or device but a drug or device that has been approved for use in the Qualified Clinical Trial, whether or not the Food and Drug Administration has approved the drug or device for use in treating the Insured Person's particular condition will be a patient care service to the extent that the drug or device is not paid for by the manufacturer, distributor or provider of the drug or device.
2. Non-health care services that an Insured Person may be required to receive as a result of being enrolled in the clinical trial.
3. Costs associated with managing the research associated with the clinical trial.
4. Costs that would not be covered for non-investigational treatments.

5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the clinical trial.
6. The costs of services that are inconsistent with widely accepted and established national or regional standards of care.
7. The costs of services that are provided primarily to meet the needs of the trial, including, but not limited to, tests, measurements and other services that are typically covered but which are being provided at a greater frequency, intensity or duration.
8. Services or costs that are not otherwise covered under this Policy.

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

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

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

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

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

The coverage shall include benefits for:

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

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

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

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

1. Equipment and supplies for the treatment of diabetes include, but are not limited to the following. We will pay the Usual and Reasonable charges incurred for such supplies.
    a. Lancets and automatic lancing devices
    b. Glucose test strips
    c. Blood glucose monitors
    d. Blood glucose monitors for visually impaired

    e. Control solutions used in blood glucose monitors;
    f. Diabetes data management systems for management of blood glucose
    g. Urine testing products for glucose and ketones
    h. Oral anti-diabetic agents used to reduce blood sugar levels
    i. Alcohol swabs
    j. Syringes
    k. Injection aids including insulin drawing up devices for the visually impaired
    l. Cartridges for the visually impaired
    m. Disposable insulin cartridges and pen cartridges
    n. Insulin pumps and equipment for the use of the pump including batteries
    o. Insulin infusion devices
    p. Oral agents for treating hypoglycemia such as glucose tablets and gels
    q. Glucagon for injection to increase blood glucose concentration
    r. Visual magnifying aids for use by the legally blind
    s. Voice synthesizers for blood glucose monitors for use by the legally blind
    t. Other diabetes equipment and related supplies to the treatment of diabetes.
2. We will pay the Usual and Reasonable charges for the following:
    a. Insulin and prescribed oral diabetes medications that influence blood sugar levels, on the same basis as other Prescription Drugs;
    b. Laboratory tests, including glycosyltated hemoglobin, or HbAlc, tests; and
    c. Therapeutic molded shoes and shoe inserts for people who have severe diabetic foot disease when the need for therapeutic shoes and inserts has been certified by the treating Physician and prescribed by a podiatrist or other qualified Physician and furnished by a podiatrist, orthotist, prosthetist or pedorthist.
3. We will also pay Reasonable and Customary charges for diabetes outpatient self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition, including medical nutrition therapy when provided by a certified diabetes health care provider. This benefit will be limited to visits where a Physician diagnoses a significant change in the Insured Person's symptoms or conditions that necessitate changes in an Insured Person's self-management or where reeducation or refresher education is necessary. Coverage also includes home visits. Such education may be provided by certified diabetes health care provider, which means:
    a. A licensed health care professional with expertise in diabetes;
    b. A registered dietician; or
    c. A health care provider certified by the National Certification Board of Diabetes Educators as a certified diabetes educator.

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

1. The necessary care and treatment of medically diagnosed congenital defects and birth abnormalities, or premature birth. Such coverage shall also include those special

medical formulas which are approved by the commissioner of the Department of Public Health, prescribed by a Physician, and are Medically Necessary for treatment of phenylketonuria, tyrosinemia, homocystinuria, maple syrup urine disease, propionic acidemia, or methylmalonic acidemia in infants and children or Medically Necessary to protect the unborn fetuses of pregnant women with phenylketonuria. Such coverage will also include screening for lead poisoning as required by the commonwealth of Massachusetts.

2. Preventive and primary care services for children. For the purposes of this paragraph Preventive Care Services means services rendered to a dependent child of an Insured from the date of birth through the attainment of six (6) years of age and shall include physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening, and assessment at the following intervals: six (6) times during the child's first year after birth, three (3) times during the next year, annually until age six (6). Such services shall also include hereditary and metabolic screening at birth, appropriate immunizations, and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by the Physician.
3. Medically Necessary early intervention services delivered by certified early intervention specialists, as defined in the early intervention operational standards by the Department of Public Health and in accordance with applicable certification requirements. Such Medically Necessary services shall be provided by early intervention specialists who are working in early intervention programs certified by the Department of Public Health, for children from birth until their third birthday. Reimbursement of costs for such services shall be part of a basic benefits package offered by Us or a third party, with a maximum benefit of $5,200 per year per child.
4. Coverage for the cost of a newborn hearing screening test to be performed before the newborn infant is discharged from the hospital or birthing center to the care of the parent or guardian or as provided by regulations of the Department of Public Health.

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

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

Hormone Replacement Therapy Services; Outpatient Contraceptive Services- We will pay the Usual and Reasonable expenses incurred for hormone replacement therapy services for peri and post-menopausal women and Outpatient Contraceptive Services under the same

terms and conditions as for such other outpatient services.

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

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

Human Leukocyte Testing- We will pay the Usual and Reasonable expenses incurred for the cost of human leukocyte antigen testing or histo compatibility locus antigen testing that is necessary to establish bone marrow transplant donor suitability. The coverage will include the costs of testing for A, B or DR antigens, or any combination thereof, consistent with rules, regulations and criteria established by the Commonwealth of Massachusetts.

Infertility Benefit - We will pay the Usual and Reasonable expenses incurred for the diagnosis and treatment of infertility to the same extent that benefits are provided for other pregnancy-related procedures, We will pay the expenses incurred for:

1. Artificial insemination (AI);
2. In vitro fertilization and embryo placement (IVF-EP);
3. Gamete intra fallopian transfer (GIFT);
4. Sperm, egg and/or inseminated egg procurement and processing and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any;
5. Intracytoplasmic sperm injection (ICSI) for the treatment of male factor infertility; or
6. Zygote intrafallopian transfer (ZIFT). For the purposes of this benefit:

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

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

We will NOT cover the following as part of an infertility treatment program:

1. Any experimental infertility procedure, until the procedure becomes recognized as non-experimental and is so recognized by the Commissioner;
2. Surrogacy;
3. Reversal of voluntary sterilization; and
4. Cryopreservation of eggs.

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

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

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

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

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

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

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

under the Policy remains in effect. We will cover inpatient, intermediate, and outpatient services that shall permit active and non-custodial treatment for said mental disorders to take place in the least restrictive clinically appropriate setting. For purposes of this section:
Confinement will mean that the Insured Person must be confined in an either:

1. A general Hospital licensed to provide such services;
2. A facility under the direction and supervision of the Department of Mental Health;
3. A private mental Hospital licensed by the Department of Mental Health; or
4. A substance abuse facility licensed by the Department of Public Health.

Outpatient care and treatment means care or treatment that is provided:

1. By a licensed Hospital;
2. By a mental health or substance abuse clinic licensed by the Department of Public Health;
3. By an approved (by the Department of Mental Health) community mental health center or other mental health clinic or day care center which furnishes mental health services; or
4. Consultations or diagnostic or treatment sessions, provided in a professional office or home based services provided, however, that such services are rendered by a licensed mental health professional including a licensed Physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, a licensed nurse mental health clinical specialist or a licensed marriage and family therapist within the lawful scope of practice for such therapist.
5. For the purposes of this Benefit, psychopharmacological services and neuropsychological assessment services shall be treated as a medical benefit and shall be on the same basis as any other Covered Sickness. Per visit limits for non-Biologically-Based Mental Disorder services do not apply to Biologically-Based Mental Disorders.

Morbid Obesity & Bariatric Surgery Benefit-We will pay the Usual and Reasonable expenses incurred for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health for the long term reversal of morbid obesity. We will pay these expenses on the same basis as for other medical and surgical procedures. As used in this Benefit:
Morbid Obesity means:

a. a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance Tables;
b. a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or
c. a BMI of 40 kilograms per meter squared without comorbidity.

BMI (Body Mass Index) means weight in kilograms divided by height in meters squared.

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

Organ Transplant Benefit – We will pay the Usual and Reasonable expenses incurred for the cost of human organ (or tissue) transplants. This coverage includes: the Harvesting of the donor's organ (or tissue) when the recipient is an Insured Person, and drug therapy that is furnished during the transplant procedure to prevent the transplanted organ (or tissue) from being rejected. **Harvesting** means the surgical removal of the donor's organ (or tissue) and the related Medically Necessary services and/or tests that are required to perform the transplant itself. This coverage does not include the Harvesting of the donor's organ (or tissue) when the recipient is not an Insured Person.

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

Pediatric Dental Care Benefit- We will pay the Usual and Reasonable expenses incurred for Routine Dental Care for Insured Students and Dependent Children up to age 12. Orthodontia is excluded (other than Medically Necessary orthodontia).
As used in this benefit: **Routine Dental Care** means dental care provided in the office of a dentist, including:

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

Pediatric Vision Care Benefit- We will pay the Usual and Reasonable expenses incurred for one Visual Examination per Policy Year for Insured Students and Dependent Children up to age 19. As used in this Benefit: **Vision Examination** means examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We will cover one vision examination in any twenty-four (24) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination must be performed by an ophthalmologist or by an optometrist.

Prosthetic Devices Benefit- We will pay the Usual and Reasonable expense incurred for Prosthetic Devices and repairs under the same terms and conditions that apply to other durable medical equipment covered under the Policy. We will pay the Usual and Reasonable expenses incurred for scalp hair prosthesis (wigs) only when hair loss is due to: chemotherapy; radiation therapy; infections; burns; traumatic injury; congenital baldness; and

medical conditions resulting in alopecia areata or alopecia totalis (capitus). Scalp hair prosthesis has a benefit limit of $500 per Policy Year which applies to the Policy Year regardless of whether benefit is paid under this benefit or the Cancer Treatment Benefit. No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging. For purposes of this benefit: **Prosthetic Device** means an artificial limb device to replace, in whole or in part, an arm or leg.

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

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

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

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

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Principal Sum for Double Dismemberment or Loss of Life is **$10,000.**

½ Principal Sum for Single Dismemberment is **$10,000.** Loss must occur within 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.

GENERAL EXCLUSIONS AND LIMITATIONS

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

1. Medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
2. Dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person's Sound, Natural Teeth.
3. Professional services rendered by an immediate family member or any who lives with the Insured Person.
4. Services or supplies not related to the medical care of the Insured Person's Injury or Sickness.
5. Services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental Injury or as specifically provided in the Schedule of Benefits.
6. Weak, strained or flat feet, corns, calluses or ingrown toenails.
7. Treatment or removal of nonmalignant moles warts, boils, acne, actinic or seborrheic keratosis, dermatofibrosis or nevus of any description or form, hallus valgus repair, varicosity**,** or sleep disorders including the testing for same.
8. Expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
9. Charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
10. Any expenses in excess of Usual and Reasonable charges.
11. Loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
12. Loss resulting from war or any act of war, whether declared or not, or loss sustained while in the armed forces of any country or international authority, unless indicated otherwise on the Schedule of Benefits.
13. Loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
14. Treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
15. Injury sustained as the result of the Insured Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.

16. Expenses incurred after the date insurance terminates as to the Insured Person
17. Treatment or care for weight increase or weight loss, except as specifically provided in the Schedule of Benefits.
18. Charges incurred for acupuncture expenses for hair growth or removal unless otherwise specifically covered under the Policy.
19. Expenses for radial keratotomy.
20. Expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
    a. For the purposes of this provision**, Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
    b. For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance).
21. Treatment to the teeth, including surgical extractions of teeth, except as specifically provided in the Schedule of Benefits. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.
22. An Insured Person's:
    a. committing or attempting to commit a felony,
    b. being engaged in an illegal occupation, or
    c. participation in a riot.
23. Custodial care service and supplies.
24. Expenses that are not recommended and approved by a Physician.
25. Private Duty Nursing except as specifically provided in the Schedule of Benefits.
26. Non-Prescription drugs or medicines such as legend vitamins, minerals, food supplements, herbs, herbal formulas, biological sera, or drugs to stimulate hair growth, except as specifically provided in the Schedule of Benefits
27. Pregnancy that results under a surrogate parenting agreement.

COORDINATION OF BENEFITS

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

CLAIM PROCEDURES

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

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

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

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

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

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

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

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

HOW TO FILE AN APPEAL

Once a claim is processed, and upon receipt of an Explanation of Benefits (EOB), an Insured Person who disagrees with how a claim was processed may appeal that decision. The Insured Person must request an appeal in writing within 180 days of the date appearing on the EOB. The appeal request must include why they disagree with the way the claim was processed. The request must include any additional information they feel supports their request for appeal, such as medical bills confirming service was received for a covered benefit.

Information should be provided to:

National Guardian Life Insurance Company

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

The Plan is underwritten by:
NATIONAL GUARDIAN LIFE INSURANCE COMPANY
Policy Form Number: NBH-280(2014) MA
Policy Number: 2015I5A93

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

Service Broker
University Health Plans, Inc.
One Batterymarch Park
Quincy, MA 02169-7454
800-437=6448
Email: info@univhealthplans.com
www.universityhealthplans.com

Claims Administrator:
Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
800-633-7867

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

Representations of this plan must be approved by Us.

IMPORTANT

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

VALUE ADDED SERVICES
Not Provided by National Guardian Life

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

EMERGENCY MEDICAL AND TRAVEL ASSISTANCE

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

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

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

or if you are in a foreign country, call collect at: 1-410-453-6330**.**

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

VISION DISCOUNT PROGRAM

For Vision Discount Benefits please go to:

www.chpstudent.com