National Guardian Life Insurance Company
It's about people.

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-0826

Underwritten by: National Guardian Life Insurance Company
Two East Gilman Street
P.O. Box 1191
Madison, WI 53701-1191

Administrator: Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
Toll-Free 877-657-5030

STUDENT HEALTH INSURANCE

National Guardian Life Insurance Company, referred to in this Policy as "We," "Us," "Our" or "the Company," issues this Policy to the Policyholder named in the Insurance Information Schedule to insure the students of a School.

INSURING AGREEMENTS

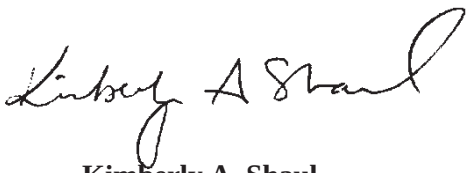
COVERAGE: Benefits are provided to cover the expenses incurred:
1. Due to a Covered Sickness or a Covered Injury; and
2. Sustained while the Policy is in force as hereinafter specifically provided.

We will pay the benefits under the terms of the Policy in consideration of:
1. The application for this Policy; and
2. The payment of all premiums as set forth in the Policy.

The Effective and Termination Dates for coverage under this Policy are as shown in the Schedule of Benefits and Rates. All time periods begin and end at 12:01 A.M., local time, at the Policyholder's address.

The following pages form a part of this Policy as fully as if the signatures below were on each page.

This Policy is executed for the Company by its President and Secretary.



Kimberly A. Shaul
Secretary

Mark L. Solverud
President

Non-Participating

Consumer Information Services

To get help solving a problem related to health care, contact:

Vermont Health Care Advocate HelpLine,
1-800-917-7787
or complete the online help request form found at: https://vtlawhelp.org/vtlegal_gethelp

To file a complaint regarding your insurance coverage, contact:

Vermont Insurance Division
Phone: (800) 964-1784
Fax: (802) 828-1446

By mail:
Department of Financial Regulation, Insurance Consumer Services
89 Main Street
Montpelier, VT 05620-3101

Or visit the website to file an online complaint:
http://www.dfr.vermont.gov/insurance/insurance-consumer/file-insurance-complaint

Service Area Requirements

Travel time for Insured Persons to a Network Provider under normal conditions should not exceed the following:

SERVICE	**TRAVEL TIME**
Primary care provider; routine, office-based mental and substance use services	30 minutes
Outpatient physician specialty care; intensive outpatient, partial hospital, residential or inpatient mental health and substance use services; laboratory; pharmacy; general optometry; inpatient; imaging; and inpatient medical rehabilitation services	60 minutes
Major trauma treatment; neonatal intensive care; and tertiary-level cardiac services, including such services as cardiac catheterization and cardiac surgery	90 minutes
Specialty services such as major burn care, organ transplant, and specialty pediatric care	Reasonable accessibility

Wait Times for the services listed should not exceed the following:

SERVICE	**WAIT TIME**
Emergency Care	Immediate
Urgent care	24 hours
Non-emergency, non-urgent care	Two weeks
Preventive care (including routine physical exams)	90 days
Routine laboratory, imaging, general optometry, and all other routine services	30 days

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INSURANCE INFORMATION SCHEDULE

POLICYHOLDER: Champlain College
Burlington, VT

POLICY NUMBER: 2018I5A07

EFFECTIVE DATE: August 9, 2018

TERMINATION DATE: August 9, 2019

The Policy Year runs from the Policy Effective date until the Policy Termination Date. The Policy Term is the period of time selected by the Insured Student and for which premium has been paid that insurance is effect while an eligible student of the Policyholder.

PREMIUM SCHEDULE

CLASS OF INSURED PERSONS	Policy Term	PREMIUM RATE
Student Only	Annual	$1,747.00
Student Only	Fall	$ 694.00
Student Only	Spring/Summer	$1,053.00

CLASSES OF PERSONS	ENROLLMENT REQUIREMENTS	ENROLLMENT PERIOD	WAITING PERIOD
New Student	12 or more credit hours	31 Days	0 Days
Continuing Student	12 or more credit hours	31 Days	0 Days
Allied Health Student	1 or more credit hours	31 Days	0 Days

STUDENT CLASSIFICATION

☒ Domestic ☒ International □ Other (Specify)

PARTICIPATION

□ Voluntary ☒ Waiver □ Mandatory □ Other (Specify)

SCHEDULE OF BENEFITS

Metal Level: Gold **Actuarial Value: 81.53%**

Benefit Period: When an Insured Person receives initial medical treatment within 30 days of the occurrence of a Covered Injury or at the onset of a Covered Sickness, eligible benefits will be provided for a continuous Benefit Period. The Benefit Period begins:

1. On the date of occurrence of such Covered Injury; or
2. From the first day of treatment of a Covered Sickness. The Benefit Period terminates at the end of:
   ☒ the Policy Term (+ Extension of Benefits - when appropriate) ☐ Other

Preventive Services:

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

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

Deductible:	Network:	$400.00
	Non-Network:	$400.00

Out-of-Pocket Expense Limit:

Non-Network & Network Combined	Individual $5,550.00
Prescription Drugs, Combined Network and Non-Network	Individual $1,350.00

Three family members must meet the individual deductible before the family will not be required to pay any further cost sharing under the deductible.

Coinsurance Amount:

Network Provider:	80% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider:	60% of Usual and Reasonable Charge for Covered Medical Expenses unless otherwise stated below.

Benefit Payment for Network Providers and Non-Network Providers

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

PREFERRED PROVIDER ORGANIZATION:

To locate a Cigna Provider Provider in Your area, consult Your Provider Directory or call toll free 1-877-657-5030 or visit www.chpstudenthealth.com.

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:

1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION;**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**

BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Inpatient Benefits		
Hospital Room & Board Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room & Board Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Preadmission Testing	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Physician's Visits while Confined	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Inpatient Surgery: Surgeon Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Anesthetist	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Assistant Surgeon	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Physical Therapy (inpatient)	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Skilled Nursing Facility Expense Benefit	The PPO Allowance stated above	The Usual and Reasonable Charge stated above

BENEFITS PER COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Outpatient Benefits		
Outpatient Surgery: Surgeon Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Anesthetist	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Assistant Surgeon	The PPO Allowance stated above	The Usual and Reasonable Charge stated 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 PPO Allowance stated above	The Usual and Reasonable Charge stated above
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy Habilitative Services are covered to the extent that they are Medically Necessary	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Emergency Services Expenses	The PPO Allowance stated above Copayment: $100.00	The PPO Allowance stated above Copayment: $100.00
In Office Physician's Visits	The PPO Allowance stated above Copayment: $25.00	The Usual and Reasonable Charge stated above Copayment: $25.00
Specialist Visits	The PPO Allowance stated above Copayment: $25.00	The Usual and Reasonable Charge stated above Copayment: $25.00
Urgent Care Centers or Facilities	The PPO Allowance stated above Copayment: $25.00	The Usual and Reasonable Charge stated above Copayment: $25.00
Diagnostic X-ray Services	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Laboratory Procedures (Outpatient)	The PPO Allowance stated above	The Usual and Reasonable Charge stated above

BENEFITS PER COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Outpatient Benefits ***(continued)***		
Prescription Drugs	100% of PPO Allowance subject to: Copayment: $15.00 Generic Copayment: $30.00 Preferred Brand Copayment: $50.00 Brand Copayment: $50.00 Specialty	No Benefit
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Home Health Care Expenses	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Hospice Care Coverage Home health aide limited to 100 hours per month Homemaker services limited to 100 hours per month	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Private Duty Nursing by Registered Nurse	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Other Benefits		
Ambulance Service	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Durable Medical Equipment Including Braces, Appliances, Prosthesis and Orthotics	The PPO Allowance stated above	The Usual and Reasonable Charge stated above
Maternity Benefit	Same as any other Covered Sickness	
Routine Newborn Care	Same as any other Covered Sickness	
Abortion Expense	The PPO Allowance stated above Copayment: $25.00	The Usual and Reasonable Charge stated above Copayment: $25.00

BENEFITS PER COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Other Benefits ***(continued)***		
Pediatric Dental Care Benefit (up to age 21) Preventive Dental Care limited to 2 dental exams every 12 months *The benefit amount payable for the following services is different from the benefit amount payable for Preventive Dental Care:*	See Benefit for limitations 100% of PPO Allowance for Preventive Services	See Benefit for limitations 80% of the Usual and Reasonable Charge for Preventive Services
Emergency Dental	50% Usual and Reasonable	50% Usual and Reasonable
Routine Dental	50% Usual and Reasonable	50% Usual and Reasonable
Endodontic Services	50% Usual and Reasonable	50% Usual and Reasonable
Prosthodontic Services	50% Usual and Reasonable	50% Usual and Reasonable
Medically Necessary Orthodontic Care	50% Usual and Reasonable	50% Usual and Reasonable
Pediatric Vision Care Benefit (up to age 21) Limited to 1 visit and 1 pair of prescribed lenses and frames per Policy Year	100% of PPO Allowance for Preventive Services	The Usual and Reasonable Charge stated above Copayment: $25.00 for exam; $50.00 for lenses and frames
Chiropractic Care Subject to a maximum number of visits of 12 per Policy Year, then prior approval after the 12th visit	The PPO Allowance stated above Copayment: $25.00	The Usual and Reasonable Charge stated above Copayment: $25.00
Transplant Services	The Coinsurance Amount Stated Above	The Usual and Reasonable Charge stated above
Bariatric Surgery	The Coinsurance Amount Stated Above	The Usual and Reasonable Charge stated above
Mental Health Disorder (Inpatient and Outpatient)	Same as any other Covered Sickness Outpatient Office Visit Copayment: $25.00	
Substance Use Disorder (Inpatient and Outpatient)	Same as any other Covered Sickness Outpatient Office Visit Copayment: $25.00	

BENEFITS PER COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
MANDATED BENEFITS		
Mammography Screening	Same as any other Preventive Service	
Dental Coverage for Anesthesia and Hospitalization	Same as any other Covered Sickness	
Diabetes Treatment	Same as any other Covered Sickness	
Prostate Screening	Same as any other Preventive Service	
Treatment of Inherited Metabolic Disease	Same as any other Covered Sickness	
Tobacco Cessation Medication	Same as any other Preventive Service	
Clinical Trials	Same as any other Covered Sickness, subject to the limitations in the benefit	
Craniofacial Disorders	Same as any other Covered Sickness	
Telemedicine	Same as any other Covered Sickness	
Early Childhood Development Disorders	Same as any other Covered Sickness	
Off-Label Prescription Drug	Same as any other Covered Sickness	
Outpatient Sterilizations	Same as any other Covered Sickness	

SECTION I - ELIGIBILITY AND PARTICIPATION BASIS

Students of the Policyholder are eligible for coverage under one of the following bases. The Insurance Information Schedule will indicate who is eligible for coverage, on what basis and enrollment requirements.

1. **Waiver Participation -** All individuals shown on the Insurance Information Schedule are eligible for insurance on a Waiver Participation Basis.

2. **International Students and/or Visiting Faculty Member -** All such individuals are eligible for this plan on a Waiver Participation Basis. All eligible International Students and/or Visiting Faculty must have and maintain a current passport and a proper student Visa (either an F-1, J-1 or M-1 category Visa).

Waiver Participation Basis means that enrollment for insurance is required of all eligible persons except those who have submitted evidence of equivalent coverage satisfactory to the Policyholder.

To be eligible for coverage under this Policy, a Student 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.

We maintain the right to investigate student status and attendance records to verify that the Policy eligibility requirements have been met. If and whenever We discover that they have not been met, our only obligation is to refund premium.

SECTION II - POLICY YEAR, PREMIUM AND PREMIUM PAYMENT

Policy Year: This Policy takes effect and terminates on the corresponding dates shown in the Insurance Information Schedule. All time periods begin and end at 12:01 A.M., local time, at the address of the Policyholder.

Premium and Premium Payment: Premium for the Policy will be calculated on the basis of the rates stated in the Premium Schedule.

The Policyholder agrees to submit to Us or Our duly authorized agent the name, effective date and any other required eligibility information for each person becoming insured hereunder. This must be done within 30 days after the effective date of each Insured Person's coverage. The information, together with payment of the premium due for such persons, must be submitted.

If We or Our duly authorized agent do not receive this information within this 30 day period, coverage on any names submitted subsequent to that period will not take effect until the date We actually receive the name of the person to be insured. Coverage is also subject to payment of any premium due.

Grace Period: The Policyholder is entitled to a grace period of 60 days for the payment of any premium due except the first, during which grace period the coverage shall continue in force.

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

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

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

No other refunds will be allowed.

SECTION III - EFFECTIVE AND TERMINATION DATES

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

The last date for enrollment is shown in the Insurance Information Schedule. The Enrollment Period will run from the start of the quarter or semester for which coverage is desired.

Termination Dates: An Insured Person's insurance will terminate on the earliest of:
1. The date this Policy terminates for all insured persons; or
2. The end of the period of coverage for which premium has been paid; or
3. The date an Insured Person ceases to be eligible for the insurance; or
4. The date an Insured Person enters military service; or
5. For International Students, the date Insured Person departs the Country of Assignment for his/her Home Country (except for scheduled school breaks);
6. For International Students, the date the student ceases to meet Visa requirements;
7. On any premium due date the Policyholder fails to pay the required premium for an Insured Person except as the result of an inadvertent error and subject to the Grace Period provision.

Dependent Child Coverage:

Newly Born Children - A newly born child of an Insured Person will be covered from the moment of birth. Such newborn child will be covered for Covered Injury or Covered Sickness for an initial period of 60 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth.

Adopted Children - Dependent Child Coverage also applies to any child adopted or placed for adoption irrespective of whether the adoption has become final. We must receive notification of a child's placement for adoption within 60 days of placement.

As it pertains to this provision:
Child means, in connection with an adoption or place for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

Placement for adoption means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of a child. The child's placement with a person terminates upon the termination of the legal obligation.

Extension of Benefits: Coverage under this Policy ceases on the Termination Date shown in the Insurance Information Schedule. However, coverage for an Insured Person will be extended as follows:

1. If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for up to one year from the Termination Date while such confinement continues; or
2. If an Insured Person is Totally Disabled due to Covered Injury or Covered Sickness, the coverage for that condition will be extended for up to twelve months from the Termination Date.

Continuous Coverage: Coverage for an Insured Person will be considered continuous during consecutive periods of insurance under this Policy:

1. When premium payment is received either in Our Home Office or by Our Agent or the Plan Administrator; and
2. Premium is received within the Enrollment Period specified in the Insurance Information Schedule.

This is regardless of any breaks in calendar days between consecutive periods of insurance.

SECTION IV – DEFINITIONS

These are key words used in this Policy. They are used to describe the Policyholder's rights as well as Ours. Reference should be made to these words as the Policy is read.

Accident means accidental bodily Injury sustained by the Insured Person and directly caused by an Accident which is not the result of disease or bodily infirmity.

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 or may not be an employee of the Hospital where the surgical procedure is performed.

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

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

Complications of Pregnancy means conditions that require Hospital confinements before the pregnancy ends and whose diagnoses are distinct from but caused or affected by pregnancy. These conditions are acute nephritis or nephrosis, cardiac decompensation, missed abortion, or similar conditions as severe as these.

Complications of Pregnancy also include non-elective cesarean section, termination of an ectopic pregnancy, and spontaneous termination when a live birth is not possible. (This does not include voluntary abortion.)

Complications of Pregnancy do not include false labor, occasional spotting or Physician prescribed rest during the period of pregnancy, morning Sickness, preeclampsia, and similar conditions not medically distinct from a difficult pregnancy.

Copayment means the amount of Usual and Reasonable 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 or visiting faculty member is:

1. Temporarily residing; and
2. Actively engaged in education or educational research related activities sponsored by the National Association for Foreign Student Affairs or its Member Organizations.

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

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

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

Covered Sickness includes Mental Health Disorders and Substance Use Disorders.

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

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 Surgery includes, but is not limited to, circumcision, 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.

Elective Treatment includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, infertility (not including diagnosis of infertility), learning disabilities, 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.

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 manifests itself by acute symptoms of sufficient severity (including severe pain) so that 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:
1. 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;
2. Serious impairment to bodily functions; or
3. 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 inpatient and outpatient Hospital services furnished by a Hospital or Physician qualified to furnish those services that are needed to evaluate or Stabilize an Emergency Medical Condition.

Essential Health Benefits mean benefits that are defined as such by the Secretary of Labor and are to be provided in a manner that is equal to the scope of benefits provided under a typical employer plan. This applies to the following general categories and the items and services covered within the categories:
1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;

4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

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.

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

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

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.

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 Care means medical treatment, including diagnostic testing, preventive services and aftercare that are appropriate, in terms of type, amount, frequency, level, setting, and duration to the Insured Person's diagnosis or condition. Medically Necessary Care must be rendered in accordance with accepted medical and scientific evidence. Such care must be consistent with generally accepted practice parameters recognized by health care professions in the same specialties as typically provide the procedure of treatment, or diagnose and manage the medical condition; and

1. Help restore or maintain the Insured Person's health; or
2. Prevent deterioration of or palliate the Insured Person's condition; or
3. prevent the reasonably likely onset of a health problem or detect an incipient problem.

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.

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 amount of Usual and Reasonable 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 means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a naturopath, an athletic trainer, 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.

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.

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

Skilled Nursing Facility – a facility, 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 the 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.

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 to perform all the substantial and material duties of his or her regular 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.

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.

SECTION V - DESCRIPTION OF BENEFITS

Benefit Payments

Preventive Services
The following services shall be covered without regard to any Deductible 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.
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.
5. Links to lists of Preventive Services covered under the Affordable Care Act are listed below.
   Preventive services for adults:
   https://www.healthcare.gov/preventive-care-adults/
   Preventive services for women:
   https://www.healthcare.gov/preventive-care-women/
   Preventive services for children:
   https://www.healthcare.gov/preventive-care-children/.

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 for Loss due to 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. Use of a Network Provider, if any.

The following are shown in the Schedule of Benefits:

- Deductible
- Any specified benefit maximums
- Coinsurance percentages
- Copayment amounts
- Out-of-Pocket Expense Limits

The Covered Medical Expenses for an issued Policy will be only those listed in Covered Medical Expenses with all applicable Deductibles, Coinsurance and Copayment amounts, and maximums for each benefit shown in the Schedule of Benefits.

Preferred Provider Organization
If an Insured Person uses a Network Provider, this 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, this 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.

Note, however, that We will pay at the PPO Allowance level for treatment by a Non-Network Provider if:
1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or
2. there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider.

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

Continuity of Care
A newly added Insured Person may continue to use his or her Non-Network Provider if such provider agrees to the terms of the contract We have in place with the Preferred Provider Organization including payment rates, quality of care standards and protocols, and the provision of necessary clinical information to the Preferred Provider Organization subject to the following:
1. If the Insured Person has a life-threatening, disabling, or degenerative condition may continue to see the Physician for sixty days from effective date of the Insured Person's coverage or until accepted by a Network Provider, whichever is shorter; and
2. A female Insured Member who is in her second or third trimester of pregnancy is allowed to continue to obtain care from her prior Physician until the completion of postpartum care.

If a Network Provider's contract with the Preferred Provider Organization terminates without cause, an Insured Person may continue to use the provider for an ongoing course of treatment if the provider agrees to the terms of the contract We have in place with the Preferred Provider Organization including payment rates, quality of care standards and protocols, and the provision of necessary clinical information to the Preferred Provider Organization, subject to the following:
1. If the Insured Person has a life-threatening, disabling, or degenerative condition may continue to see the Physician for sixty days from effective date of the Insured Person's coverage or until accepted by a Network Provider, whichever is shorter; and
2. A female Insured Member who is in her second or third trimester of pregnancy is allowed to continue to obtain care from her prior Physician until the completion of postpartum care.

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 this 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. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person's Coinsurance amounts, Deductibles and Copayments will apply toward the Out-of-Pocket Expense Limit.

Basic Injury and Sickness Benefit

If:

1. an Insured Person incurs expenses as the result of Covered Injury or Covered Sickness, then
2. We will pay the benefits stated in the Schedule of Benefits for the services, treatments and supplies described in the Covered Medical Expenses provision below.

Payment will be made, Subject to the Coinsurance, Deductible, Copayment, maximums and limits as stated in the Schedule of Benefits:

1. For the Usual and Reasonable Charges for Covered Medical Expenses that are incurred as the result of a Covered Injury or Covered Sickness; and
2. Subject to the Exclusions and Limitations provision.

Covered Medical Expenses

We will pay the Covered Medical Expenses when they are incurred as the result of a Covered Injury or Covered Sickness. **The Covered Medical Expenses for an issued Policy will be only those listed below and as shown in the Schedule of Benefits.**

Inpatient Benefits

1. **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.

2. **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.**

3. **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.

4. **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.

5. **Physician's Visits while Confined** not to exceed one visit per day, unless Medically Necessary. 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.

6. **Inpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** (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 not pay a full allowance for each one. This benefit is not payable in addition to Physician's visits.

7. **Physical Therapy while Confined** when prescribed by the attending Physician.

8. **Skilled Nursing Facility Benefit** for services received in a licensed Skilled Nursing Facility. Services must be Medically Necessary. Confinement for custodial care or residential care is not covered.

Outpatient Benefits

1. **Outpatient Surgery including Surgeon, Anesthetist, and Assistance Surgeon Services** 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 not pay a full allowance for each one.

2. **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.

3. **Rehabilitative and Habilitative Therapy** when prescribed by the attending Physician, limited to one visit per day.

4. **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.

5. **In Office Physician's Visits** for Physician's office visits. We will not pay for more than one visit per day, unless Medically Necessary. Physician's Visit benefits will be paid for either outpatient or inpatient visits on the same day, but not both. Surgeon fees are NOT payable under this benefit.

6. **Urgent Care Centers or Facilities** for services provided at an Urgent Care Center or Facility, as shown in the Schedule of Benefits. We will not pay for more than one visit per day.

7. **Diagnostic X-ray Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.

8. **Laboratory Procedures (Outpatient)** for laboratory procedures as shown in the Schedule of Benefits when prescribed by a Physician.

9. **Prescription Drugs** 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.

   a. 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:
      1. The drug is approved by the FDA;
      2. The drug is prescribed for the treatment of a life-threatening condition, including cancer, HIV or AIDS;

3. 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 States 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 of this benefit.

b. Investigational Drugs and Medical Devices – The Prescription Drug benefit includes a drug or device that is investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

c. Specialty Drugs – are Prescription Drugs which:
   1. Are only approved to treat limited patient populations, indications, or conditions; or
   2. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
   3. 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. Contraceptives – We will provide coverage for a 12 month supply of contraceptives which may be dispensed all at once or over the course of the 12 months at the discretion of the Provider. We will also provide coverage with no Deductible, Coinsurance, Copayment, or other cost-sharing for at least one drug, device, or other product in each contraceptive method for women identified by the FDA and prescribed by a Physician. See the link for list of contraceptive methods identified by the FDA.
   https://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm522453.htm.

10. **Outpatient Miscellaneous Expenses (Excluding surgery)** 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.

11. **Home Health Care Expense** for Home Health Care for an Insured Person when, otherwise, Hospitalization or confinement in a skilled nursing facility would have been necessary.

12. **Hospice Care Coverage** when, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the 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 months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare. We will pay the expenses incurred for a home health aide for up to 100 hours per month for personal care services only and for the expenses incurred for up to 5 days or 120 hours for the Insured Person's continuous care in the Insured Person's home. We will pay the expenses incurred of up to 72 hours each month for Respite Care. We will also pay the expenses incurred of up to 6 visits before the Insured Person's death and up to 2 bereavement visits following the Insured Person's death. These visits may include: counseling and emotional support; assessment of social and emotional factors related to the Insured Person's condition; assistance in resolving problems; assessment of financial resources; and use of available community resources.

As used in this benefit:
Hospice Care means a coordinated program of home and inpatient care provided directly or under the direction of a properly licensed Hospice. Such services will include palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal illness utilizing a medical directed interdisciplinary team.

Palliative care means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of the patient as he or she experiences the stress of the dying process, rather than at treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

Respite care means care that relieves the Insured Person's family or care givers by providing temporary relief from the duties of caring for the Insured Person's terminal illness. Respite Care will be provided in a general Hospital or in the Insured Person's home, whichever is most appropriate.

13. **Private Duty Nursing by a Registered Nurse**, when private duty nursing care is prescribed by the attending Physician for a Covered Injury or Sickness.

Other Benefits

1. **Ambulance Service** for transportation to or from a Hospital by ambulance.

2. **Durable Medical Equipment** for the rental or purchase of durable medical equipment, including, but not limited to, Hospital beds, wheel chairs, and walkers. We will pay the lesser of either the rental or purchase charges, but not both. Such equipment must be prescribed by a Physician and a copy of the written prescription must accompany the claim. Durable medical equipment must:
   a. Be primarily and customarily used to serve a medical, rehabilitative purpose;
   b. Be able to withstand repeated use; and
   c. Generally not be useful to a person in the absence of Injury or Sickness.

   This benefit also includes braces and appliances which includes prosthesis and orthotics when prescribed by the attending Physician as being necessary for the treatment of a Covered Injury or Covered Sickness. Dental braces, except when necessitated by an Injury, are not covered. We will also not pay for braces and appliances used as protective devices during a student's participation in sports. Replacement braces and appliances are not covered.

3. **Maternity Benefit** for maternity charges as follows:
   a. Routine prenatal care

   b. **Hospital stays** for mother and newly born child will be provided for up to 48 hours for normal vaginal delivery and 96 hours (not including the day of surgery) for a caesarean section delivery unless the caesarean section delivery is the result of Complications of Pregnancy. If the delivery is the result of Complications of Pregnancy, the Hospital stay will be covered the same as for any other Covered Sickness.

      Services covered as inpatient care will include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric and nursing professionals.

   c. **Inpatient Physician charges or surgeon charges** will be covered the same as for any other Covered Sickness for both mother and newborn child.

   d. **Physician-directed Follow-up Care** including:
      1) Physician assessment of the mother and newborn;
      2) Parent education;
      3) Assistance and training in breast or bottle feeding;
      4) Assessment of the home support system;
      5) Performance of any prescribed clinical tests; and
      6) Any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric obstetrical and nursing professionals.

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

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

4. **Routine Newborn Care -** when expenses are incurred for routine newborn care during the first 60 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:
   a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   b. Inpatient Physician visits for routine examinations and evaluations;
   c. Charges made by a Physician in connection with a circumcision;
   d. Routine laboratory tests;
   e. Postpartum home visits prescribed for a newborn;
   f. Follow-up office visits for the newborn subsequent to discharge from a Hospital; and
   g. Transportation of the newborn to and from the nearest appropriately staffed and equipped facility for the treatment of such newly born child. The benefit payable for transportation will not exceed the Usual and reasonable charges.

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

6. **Pediatric Dental Care Benefit** for the following dental care services for Insured Persons up to age 21.
   a. Emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma.

   b. Preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:
      1) Prophylaxis (scaling and polishing the teeth at six (6) month intervals;
      2) Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
      3) Sealants on unrestored permanent molar teeth; and
      4) Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

   c. Routine Dental Care: We Cover routine dental care provided in the office of a dentist, including:
      1) Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
      2) X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
      3) Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
      4) In-office conscious sedation;
      5) Amalgam, composite restorations and stainless steel crowns; and
      6) Other restorative materials appropriate for children.

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

e. Prosthodontic services as follows:
   1) Removable complete or partial dentures, including six (6) months follow- up care; and
   2) 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:
   1) For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
   2) For cleft palate stabilization; or
   3) Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

f. Orthodontics used to help restore oral structures to health and function and to treat serious medical conditions 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.
   Procedures include but are not limited to:
   1) Rapid Palatal Expansion (RPE);
   2) Placement of component parts (e.g. brackets, bands);
   3) Interceptive orthodontic treatment;
   4) Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
   5) Removable appliance therapy; and
   6) Orthodontic retention (removal of appliances, construction and placement of retainers).

7. **Pediatric Vision Care Benefit** for Insured Persons who are age 18 and under. We will provide benefits for:
   a. One vision examination per Policy Year; and
   b. One pair of prescription lenses and eyeglass frames every Policy Year.

8. **Chiropractic Care Benefit** for treatment of a Covered Injury or Covered Sickness and performed by a Physician. Prior approval is required after the 12th visit.

9. **Transplant Services** for the live donor's surgical expenses and storage and transportation of the organ. Costs for a donor must be incurred within 120 days from the date of the donor's surgery. We will provide benefits for Insured Persons from 30 days before the transplant to 365 days after the transplant for bone marrow transplants or from 5 days before the transplant to 365 days after the transplant. We will also provide for the search, removal, storage and transportation of the organ from a deceased donor.

10. **Bariatric Surgery** for Insured Persons when it is Medically Necessary.

Mandated Benefits for Vermont

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.

Mammography Screening for the Usual and Reasonable expenses incurred for a mammography screening as follows:
a. Any insured female less than forty (40) years of age shall be entitled to a mammography screening upon their Physician's recommendation; and
b. Any insured female forty (40) years of age or older shall be entitled to coverage for an annual mammography screening.

We will cover mammograms including but not limited to digital mammography, screening breast tomosynthesis and computer aided detection.

Dental Coverage for Anesthesia and Hospitalization Benefit for the Usual and Reasonable for anesthesia expenses including anesthesia practitioner expenses for the administration of the anesthesia, and hospital and ambulatory surgical center expenses associated with any Medically Necessary dental procedure when provided to an Insured Person who is:

a. Severely disabled; or
b. A minor insured Dependent seven (7) years of age or under, and who is determined by a licensed dentist to be unable to receive Medically Necessary dental treatment in an outpatient setting, where the provider treating the minor certifies that due to the minor's age and condition, hospitalization or general anesthesia in a Hospital or ambulatory surgical center is required in order to perform significantly complex dental procedures safely and effectively; or
c. A minor insured Dependent twelve (12) years of age or under, who in the judgment of the practitioner treating the child, is not of sufficient emotional development to undergo a Medically Necessary dental procedure without the use of anesthesia.

We do not pay for the Physician's expenses unless otherwise covered under federal law.

Diabetes Treatment for the equipment, supplies and outpatient self-management and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such items under law. We may require that such prescriptions be made, and care be given, by a health care professional under contract with Us. Diabetes outpatient self-management training and education required to be covered by this section shall be provided by a certified, registered or licensed health care professional with specialized training in the education and management of diabetes. This benefit also provides routine foot care for the treatment of diabetes only.

Prostate Screening for prostate cancer screenings consistent with the recommendations by the Centers for Disease Control and Prevention or upon recommendation of a health care provider. Benefits shall be at least as favorable as coverage for other cancer screening procedures and subject to the same dollar limits, deductibles, and coinsurance factors within the provisions of the Policy.

Treatment of Inherited Metabolic Diseases for medical foods prescribed for Medically Necessary treatment for an inherited metabolic disease. Coverage for low protein modified food products prescribed for Medically Necessary treatment of an inherited metabolic disease shall be at least $2,500 during any continuous period of 12 months for any Insured Person.

Tobacco Cessation Medication, including over-the-counter medication, if prescribed by a licensed health care practitioner for an Insured Person of at least two ninety (90) day supplies per Policy Year.

Clinical Trials for the coverage of routine costs for Insured Persons who participate in an approved cancer clinical trial conducted under the auspices of the following cancer care providers: Vermont Cancer Center at Fletcher Allen Health Care; the Norris Cotton Cancer Center at Dartmouth-Hitchcock Medical Center; and approved clinical trials administered by a Hospital and its affiliated, qualified cancer care providers. If an Insured Person participates in a clinical trial administered by a cancer care provider that is a Non-Network Provider, We may require that routine follow-up care be provided by a Network Provider, unless the cancer care provider determines this would not be in the best interest of the Insured Person.

Craniofacial Disorders for diagnosis and Medically Necessary Treatment, including surgical and nonsurgical procedures, for a musculoskeletal disorder that affects any bone or joint in the face, neck or head and is the result of Accident, trauma, congenital defect, developmental defect, or pathology. This benefit shall not be construed to require coverage for dental services for the diagnosis or Treatment of dental disorders or dental pathology primarily affecting the gums, teeth, or alveolar ridge.

Telemedicine for telemedicine services delivered to an Insured Person in a health care facility to the same extent that the services would be covered if they were provided through in-person consultation.

Early Childhood Development Disorders for the evidence-based diagnosis and Treatment of early childhood disorders, including applied behavior analysis supervised by a nationally board-certified behavior analyst, for children, beginning at birth and continuing until the child reaches age 26. We will also cover applied behavior analysis when the services are provided or supervised by a licensed provider who is working within the scope of his or her license or who is a nationally board-certified behavior analyst. The amount, frequency, and duration of Treatment described in this benefit shall be based on what is Medically Necessary.

Off-Label Prescription Drug for use in cancer Treatment in accordance with the following:

a. We may not exclude coverage for any drug used for the Treatment of cancer on the grounds that the drug has not been approved by the FDA, provided the use of the drug is medically accepted indication for the Treatment of cancer.
b. Coverage of a drug required by this benefit also includes Medically Necessary services associated with the administration of the drug.
c. This benefit shall not be construed to require coverage for a drug when the FDA has determined its use to be contraindicated for Treatment of the current indication.
d. A drug use that is covered under subsection "a" may not be denied coverage based on a medical necessity requirement except for a reason unrelated to the legal status of the drug use.

Outpatient Sterilizations for Insured Persons will be covered the same as for any other Preventive Service.

SECTION VI - 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.

This Policy does not cover loss nor provide benefits for any of the following, except as otherwise provided by the benefits of this Policy and as shown in the Schedule of Benefits.

- **International Students Only -** Eligible expenses within the Insured Person's Home Country 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.
- routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
- medical services rendered by provider employed for or contracted with the School, including team physicians, except as specifically provided in the Schedule of Benefits.
- professional services rendered by an Immediate Family Member or any who lives with the Insured Person.
- services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
- expenses for radial keratotomy and services or supplies in connection with eye examinations, eyeglasses or contact lenses or hearing aids, except those resulting from a covered accidental Injury or as provided by the Pediatric Vision Care Benefit.
- weak, strained or flat feet, corns, calluses or ingrown toenails, unless Medically Necessary.
- diagnostic or surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
- birth control, including elective surgical procedures or devices, except as specifically provided in the Schedule of Benefits.
- expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- 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.
- any expenses in excess of Usual and Reasonable charges.
- 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.
- 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.
- services that are duplicated when provided by both a certified nurse-midwife and a Physician.

- expenses payable under any prior Policy which was in force for the person making the claim.
- expenses incurred during a Hospital emergency room visit which is not of an emergency nature.
- 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.
- expenses incurred after:
  - The date insurance terminates as to the Insured Person; and
  - The end of the Benefit Period specified in the Benefit Schedule.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
- charges incurred for acupuncture, in any form, except to the extent provided in the Schedule of Benefits.
- expenses for weight increase or reduction, except Medically Necessary bariatric surgery, and hair growth or removal, except when Medically Necessary, unless otherwise specifically covered under the policy.
- expenses incurred for Plastic or Cosmetic Surgery, unless they result directly from a Covered Injury that necessitates medical treatment within 24 hours of the Accident or results from Reconstructive Surgery.
  - For the purposes of this provision**, Reconstructive Surgery** means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to either improve function or to create a normal appearance, to the extent possible.
  - For the purposes of this provision, **Plastic or Cosmetic Surgery** means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance. This exclusion does not include gender dysphoria surgery when Medically Necessary.
- treatment to the teeth, including surgical extractions of teeth. Such a procedure must be considered Medically Necessary based on the Policy definition of same. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits except as provided under the Pediatric Dental Care Benefit.
- an Insured Person's:
  - committing or attempting to commit a felony,
  - being engaged in an illegal occupation, or
  - participation in a riot.
- allergy treatment, unless Medically Necessary.
- custodial care service and supplies.
- hernia, of any kind, unless Medically Necessary.
- expenses that are not recommended and approved by a Physician.

Third Party Refund - When:
1. an Insured Person is injured through the negligent act or omission of another person (the "third party"); and
2. benefits are paid under the Policy as a result of that Injury,

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

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

COORDINATION OF THIS POLICY'S BENEFITS WITH OTHER 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

1. 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.
   a. 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; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.
   b. Plan does not include: 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.

Each Policy for coverage under a. or b. 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.

2. 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.

3. 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.

4. 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:
   a. 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.
   b. 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.
   c. 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.
   d. 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.
   e. 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.

5. 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.

6. 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. (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. 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.

(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. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(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.

SECTION VII - GENERAL POLICY PROVISIONS

Entire Contract. Changes: This Policy, including the endorsements and attached papers, if any, constitutes the entire contract of insurance. No change in this Policy will be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon. No agent has authority to change this Policy or waive any of its provisions.

Notice of Claim: Written notice of a claim must be given to Us within 20 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.

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, 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. 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.

Time of Payment: Indemnities payable under this Policy will be paid immediately upon receipt of due proof of such Loss. If it is not paid within 30 days following receipt of the claim, interest will accrue on the claim at the rate of twelve percent (12%) per annum.

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 $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.

Physical Examination and Autopsy: We, at Our own expense, 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.

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.

SECTION VIII - ADDITIONAL PROVISIONS

1. We do not assume any responsibility for the validity of assignment.

2. The Insured Person will have free choice of a legally qualified Physician with the understanding that the Physician-patient relationship will be maintained.

3. Our acknowledgment of the receipt of notice given under this Policy, or the furnishing of forms for filing proofs of loss or acceptance of such proof, or the investigation of any claim hereunder will not operate as a waiver of any of Our rights in defense of any claim arising under this Policy.

4. This Policy is not in lieu of and does not affect any requirement of coverage by Workers' Compensation Insurance.

5. All new persons in the groups or classes eligible to and applying for this insurance will be added in the respective groups or classes in which they are eligible.

6. The insurance of any Insured Person will not be prejudiced by the failure on the part of the Policyholder to transmit reports, pay premium or comply with any of the provisions of this Policy when such failure is due to inadvertent error or clerical mistake.

7. All books and records of the Policyholder containing information pertinent to this insurance will be open to examination by Us during the Policy term and within one year after the termination of this Policy.

8. Benefits are payable under this Policy only for those expenses incurred while the Policy is in effect as to the Insured Person. 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.

SECTION IX – APPEALS PROCEDURE

For purposes of this Section, the following definitions apply:

Adverse Determination means a determination by Us or Our designee utilization review organization that an admission, availability of care, continued stay or other health care service that is a Covered Medical Expense has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied, reduced or terminated. Denials of coverage based on a determination that a service recommended or requested health care or treatment is experimental also are Adverse Determination and must comply with procedures for reviewing coverage denials based on an determination that a recommended or requested health care service or treatment is experimental.

Experimental or Investigational Services means health care items or Treatment that are:
1. Not generally accepted by informed health care providers in the United States as effective in treating the condition, illness, or diagnosis for which the item or Treatment is proposed; or

2. Not proven by medical or scientific evidence to be effective in treating the condition, illness or diagnosis for which the item or Treatment is proposed.

Prospective Review means utilization review conducted prior to an admission or course of treatment.

Retrospective Review means a review of Medical necessity conducted after services have been provided to an Insured Person but does not include the review of the claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

Internal Review Procedure

1. In the event of an Adverse Determination, We will notify the Insured Person immediately in writing of Our decision and the reason for the Adverse Determination. The notice will include a description of any additional information that might be necessary for reconsideration of the claim and the notice will also describe the right to appeal. The Insured Person also has the right to contact the Commissioner of Insurance or his or her office at any time if We cannot provide a satisfactory solution to the Insured Person's complaint. The Office of Health Care Advocate can also provide information and help with appeals.
   Consumer Services
   Department of Financial Regulation
   89 Main Street
   Montpelier, VT 05620
   Phone: 1-800-964-1784 or 1-802-828-3302

   The Office of Health Care Advocate
   P.O. Box 1367
   264 North Winooski Avenue
   Burlington, VT 05402
   Phone: 1-800-917-7787 or 1-802-863-2316
   TDD: 1-888-884-1955 or 1-802-863-2473

2. A written appeal for a first level review, along with any additional information or comments, must be sent within 180 days after notice of an Adverse Determination. The Insured Person does not have the right to attend, or have an authorized representative in attendance at the first level review. However, in preparing the appeal, the Insured Person or his or her authorized representative may:
   a. review all documents related to the claim and submit written comments and issues related to the denial; and
   b. submit written comments, documents, records or other materials related to the request for benefits for the reviewer(s) to consider.

   We will provide the Insured Person with the contact person who is coordinating the first level review within 3 days of the date of receipt of the grievance.

   After the written notice is filed and all relevant information is presented, the claim will be reviewed and a final decision will be sent either in writing or electronically to the Insured Person within 30 days for a Prospective Review request or 60 days for a Retrospective Review request after receipt of the notice requesting the first level review.

   We shall provide free of charge to the Insured Person, or the Insured Person's authorized representative, any new or additional evidence, relied upon or generated by Us, or at Our direction, in connection with the grievance sufficiently in advance of the date the decision is required to be provided to permit the Insured Person, or the Insured Person's authorized representative, a reasonable opportunity to respond prior to the date.

   Before We issue or provide notice of a final Adverse Determination that is based on new or additional rationale, We shall provide the new or additional rationale to the Insured Person, or the Insured Person's authorized representative, free of charge as soon as possible and sufficiently in advance of the date the notice of final Adverse Determination is to be provided to permit the Insured Person, or the Insured Person's authorized representative a reasonable opportunity to respond prior to the date.

In the case of an Adverse Determination involving utilization review, We will designate an appropriate clinical peer(s) of the same or similar specialty as would typically manage the case being reviewed to determine Adverse Determination. The clinical peer(s) shall not have been involved in the initial adverse determination. We shall ensure that the individuals reviewing the Adverse Determination have appropriate expertise.

Expedited reviews of grievances involving an Adverse Determination

We shall provide expedited review of a grievance involving an Adverse Determination with respect to concurrent review urgent care requests involving an admission, availability of care, continued stay or health care service for an Insured Person who has received Emergency Services, but has not been discharged from a facility.

Pre-Service Grievances

The following grievances will be treated as urgent.

a. Pre-service Mental Health Disorder and Substance Use Disorders grievances will be expedited unless:
   1) the Insured Person has authorization for the treatment in dispute such that treatment can continue uninterrupted for the duration of any non-expedited grievances and independent external review, if any;
   2) the request is for a service scheduled sufficiently in the future such that non-expedited grievance(s) and independent external review, if any, can be completed prior to the date scheduled for the service; or
   3) the managed care organization otherwise has good cause to believe that it is not medically necessary to expedite the timeframe for grievance review, and the Insured Person and Physician agree.

b. Pre-service pharmacy benefit grievances are urgent unless:
   1) The Insured Person has a sufficient supply of the medication in dispute to ensure that treatment can continue uninterrupted for the duration of any non-expedited grievance and independent external review, if any;
   2) We have good cause to believe that it is not medically necessary to expedite the timeframe for grievance review, and the Insured Person and Physician agree; or
   3) The grievance is related to contract terms, limitations or exclusions.

c. Certain Prescription Drugs for cancer Treatment. All pre-service requests related to whether use of a Prescription Drug for the treatment of cancer is medically necessary or is an Experimental or Investigational will be expedited.

d. Grievances designated as urgent by the Physician or Insured Person. Any grievance designated as expedited by an Insured Person's health care provider or by the Insured Person will be treated as urgent.

The Insured Person or the Insured Person's authorized representative shall request an expedited review orally or in writing. We will appoint an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed to review the Adverse Determination. The clinical peer or peers shall not have been involved in making the initial Adverse Determination. In an expedited review, all necessary information, including the health carrier's decision, shall be transmitted between the Insured Person or, if applicable, the Insured Person's authorized representative and Us by telephone, facsimile or the most expeditious method available. An expedited review decision shall be made and the Insured Person or, if applicable, the Insured Person's authorized representative shall be notified of the decision within seventy two (72) hours after the receipt of the request for the expedited review. If the expedited review is of a grievance involving an Adverse Determination with respect to a concurrent review urgent care request, the service shall be continued without liability to the Insured Person until the Insured Person has been notified of the determination.

If the Insured Person Disagrees with Our Internal Review Determination

In the event that the Insured Person disagrees with Our internal review determination, the Insured Person or his or her authorized representative may:

a. File a complaint with the Department of Financial Regulation, 89 Main Street, Montpelier, VT 05620, Phone: 1-800-964-1784 or 1-802-828-3302; website: www.dfr.vermont.gov; or
b. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

The Insured Person also has the right to bring a civil action in a court of competent jurisdiction. Note that he or she may also have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the state Insurance Commissioner.

External Review Procedure

1. An external review shall be conducted in accordance with this section entitled External Review Procedure once the internal grievance procedures have been exhausted or We failed to notify the Insured Person of a final decision within 30 days for a Prospective Review request or 60 days for a Retrospective Review request. If an Insured Person has an Adverse Determination based on an Experimental or Investigative Treatment, the provision entitled External Review of Denial of Experimental or Investigative Treatment will apply.

   We shall notify the Insured Person in writing of the Insured Person's right to request an external review at the time the We send written notice of:
   a. An Adverse Determination upon completion of the Our utilization review process described above; or
   b. A final Adverse Determination.

   An external review may be requested within 60 days after the Insured Person receives Our adverse benefit determination. The request needs to be accompanied by a signed authorization by the Insured Person to release their medical records as necessary to conduct the external review.

2. An external review may be requested by the Insured Person or an authorized representative of the Insured Person.

3. The external review must be requested in writing, except if an expedited review is needed. A request for an expedited review may be made orally or electronically.

4. We will review the request and if it is:
   a. Complete we will initiate the external review and notify the Insured Person of:
      i. The name and contact information for the assigned independent review organization or the Commissioner of Insurance, as applicable for the purpose of submitting additional information; and
      ii. A statement that the Insured Person may submit, in writing, additional information for either the independent review organization or the Commissioner of Insurance to consider when conducting the external review. However, this doesn't apply to expedited request or external reviews that involve an experimental or investigational treatment.
   b. If the request is not complete, We will inform the Insured Person in writing, including what information is needed to make the request complete.

5. We will not afford the Insured Person an external review if:
   a. The Commissioner of Insurance has determined that the health care service is not covered under the terms of Our Policy or Certificate; or
   b. The Insured Person has failed to exhaust Our internal review process; or
   c. The Insured Person was previously afforded an external review for the same denial of coverage and no new clinical information has been submitted to Us.

   If We deny a request for an external review on the basis that the adverse benefit determination is not eligible for an external review, We will notify the Insured Person in writing:
   a. The reason for the denial; and
   b. That the denial may be appealed to the Commissioner of Insurance.

6. <u>For an expedited review</u>: the Insured Person may make a request for an expedited external review after receiving an adverse benefit determination if:
   a. The Insured's treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time frame of an expedited internal review.
   b. The Insured Person's treating Physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person, or would jeopardize the Insured Person's ability to regain maximum function, if treated after the time frame of a standard external review. or

c. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.

7. An Insured Person shall not be required to pay for any part of the cost of the review. The cost of the review shall be borne by Us, the insurer.

8. At the request of the independent review organization, the Insured Person, provider, health care facility rendering health care services to the Insured Person, or Us shall provide any additional information the independent review organization requests to complete the review.

9. If the independent review organization does not receive any requested information necessary to complete the review they are not required to make a decision. They shall notify the Insured Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means.

10. We may elect to cover the service requested and terminate the review. We shall notify the Insured Person and all other parties involved with the decision by mail, or with the consent or approval of the Insured Person, by electronic means.

11. In the case of an expedited review, the independent review organization shall issue a written decision within seventy-two (72) hours after being assigned an expedited external review. In all other cases, written decision shall be issued no later than thirty (30) days after the filing of the request for review to the Insured Person, the insurer and the Insured Person's provider or the health care facility if they requested the review. The written decision shall include a description of the Insured Person's condition and the principal reasons for the decision and an explanation of the clinical rationale for the decision.

12. We shall provide any coverage determined by the independent review organization's decision to be medically necessary, subject to the other terms, limitations, and conditions of the Insured Person's policy or certificate.

External Review of Denial of Experimental or Investigative Treatment

Within sixty (60) days after the date of receipt of a notice of an Adverse Determination or final Adverse Determination that involves a denial of coverage based on a determination that the health care service or treatment recommended or requested is experimental or investigational, an Insured Person or the Insured Person's authorized representative may file a request for external review with the Commissioner of Insurance.

An Insured Person or the Insured Person's authorized representative may make an oral request for an external review of the Adverse Determination or final Adverse Determination if the Insured Person's treating Physician certifies, in writing, that the recommended or requested health care service or treatment that is the subject of the request would be significantly less effective if not promptly initiated.

Upon receipt of a request for an expedited external review, the Commissioner of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Commissioner of Insurance immediately shall notify and send a copy of the request to Us. For an expedited external review request, at the time We receive the notice, We or Our designee utilization review organization shall provide or transmit all necessary documents and information considered in making the Adverse Determination or final Adverse Determination to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious manner.

National Guardian® Life Insurance Company
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A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

Administrative Office: Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104

ADMINISTRATIVE CHANGE ENDORSEMENT

ENDORSEMENT SCHEDULE		
Policy Owner	Attached to Policy No.	Effective Date of Coverage
Champlain College	2018I5A07	August 9, 2018

It is understood and agreed that the Policy to which this Endorsement is attached is amended as follows:

1. The following benefit will be included in the **Schedule of Benefits**:

BENEFITS FOR COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Non-Emergency Treatment outside the United States	The Coinsurance Amount stated above	

Non-Emergency Treatment outside the United States for non-emergency treatment of Covered Medical Expenses received when the Insured Person is traveling outside the United States.

In every other way, the Policy remains as is.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

Mark F Solveson

President

X_____
Policy Owner's Signature
(If required by the Company)

_____
Countersignature of Licensed
Resident Agent, where required

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Pediatric Vision Care Rider

The Policy to which this Rider is attached is amended as described below.

The Pediatric Vision Care benefit is deleted in its entirety and replaced with the following:

7. **Pediatric Vision Care Benefit** for one vision exam for an Insured Persons up to the end of the Policy Year in which the Insured Person reaches age 21. Benefits for vision materials are:
   a. One pair of prescription lenses and eyeglass frames per Policy Year; or
   b. One pair of contact lenses and related professional service per policy year.

There are no other changes to the Policy.

In Witness whereof, Our president and secretary signed this rider as of the effective date of the Policy.

Kimberly A. Shaul
Secretary

Mark L. Solverud
President

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PRESCRIPTION DRUG RIDER

The Policy to which this Rider is attached is amended as described. This Rider is effective on the issue date of the Policy.

The Prescription Drug Benefit description shown in the Schedule of Benefits is deleted in its entirety. It is replaced with the Prescription Drug benefit description below.

Prescription Drugs Retail Pharmacy Cost sharing does not apply to Affordable Care Act (ACA) Preventive Care prescriptions are filled at a participating network pharmacy.		
DESCRIPTION	**NETWORK**	**NON-NETWORK**
Retail		
TIER 1 Generic	100% of PPO Allowance for Covered Medical Expenses Copayment: $15.00	Not Covered
TIER 2 Preferred Brand Drug	100% of PPO Allowance for Covered Medical Expenses Copayment: $30.00	Not Covered
TIER 3 Non-Preferred Drug	100% of PPO Allowance for Covered Medical Expenses Copayment: $50.00	Not Covered
Specialty Prescription Drugs		
TIER 4 Specialty Prescription Drugs	100% of PPO Allowance for Covered Medical Expenses Copayment: $50.00	Not Covered

The **Definitions** section of the Policy is amended by deleting definitions of Brand Name Drug, Formulary, and Generic Drug.

The **Definitions** Section of the Policy is amended by adding the definitions below.
Brand-Name Drug means a Prescription Drug which protected by a patent and is sold by a drug company under a specific name or trademark. The tier status is shown in the Formulary.

Formulary means a list of medications covered by the Policy. Use of medications listed the Formulary is intended 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 lists the type of drug and tier status.

Generic Prescription Drug a Prescription Drug that is identical or a bioequivalent to a Brand-Name drug in dosage form, safety, strength, route of administration, quality, performance characteristics, and intended use. A Generic Prescription Drug is not protected by a patent. The tier status is shown in the Formulary.

Prescription Drug means a medication that, by law, requires a prescription.

Off-Label Drug Treatment means a drug that is prescribed for a use different from the use for which it was approved for marketing by the Federal Food and Drug Administration (FDA).

The Prescription Drugs benefit is deleted in its entirety from the **Description of Benefits** section of the Policy. It is replaced with the benefit described below.

9. Prescription Drugs

Outpatient Prescription Drug benefits are payable for Physician-prescribed drugs for an Insured Person when the drugs are obtained from an outpatient pharmacy. We will pay up to the amount shown in the Schedule of Benefits for such medication. The medication must be Medically Necessary for the Treatment of the Covered Injury or Covered Sickness for which a claim is made. Some outpatient Prescription drugs are subject to pre-certification.

1. **Off-Label Drug Treatments** benefits are available if all of the conditions listed below are met. It is the responsibility of the prescribing Physician to submit documentation to Us that supports compliance with these conditions.
   a. The drug is approved by the FDA;
   b. The drug is prescribed for the Treatment of a Life-Threatening condition, including cancer, HIV or AIDS;
   c. 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 States 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.

      As used in this benefit, Life-Threatening means:
      1) A disease or condition where the likelihood of death is high unless the course of the disease is interrupted; or
      2) Disease or condition which may be fatal and where the end point of clinical intervention is survival.

2. **Dispense as Written** benefits for Prescription Drugs will be paid as follows:
   a. If the prescribing Physician specifies “Dispense as Written”, the Insured Person will be responsible for the Brand-Name Prescription Drug Copayment described in the Schedule of Benefits.
   b. If the Prescribing Physician does not specify “Dispense as Written” and the Insured Person requests a covered Brand-Name Prescription Drug when a equivalent Generic Prescription Drug is available, the Insured Person will be responsible for the cost difference between the Brand-Name Prescription Drug and the equivalent Generic Prescription Drug and the Brand-Name Prescription Drug Copayment described in the Schedule of Benefits.
      As used in this benefit, Dispense as Written means a prescription for a covered Brand-Name Prescription Drug for which an equivalent Generic Prescription Drug is available.

3. **Investigational Drugs and Medical Devices** benefits are payable for a drug or device that is investigational if the intended use of the drug or device is included in the labeling authorized by the FDA or if the use of the drug or device is recognized in one of the standard reference compendia or in peer-reviewed medical literature.

4. **Tobacco cessation prescription and over-the-counter (OTC) drugs** benefits are payable for tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. Any additional prescription drugand OTC drug treatment regimens will be subject to the cost sharing in the Schedule of Benefits. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.chpstudenthealth.com or call 877-657-5030.

LIMITATIONS AND EXCLUSIONS
The Limitations and Exclusions described below apply only to this Prescription Drug Rider.

LIMITATIONS

1. **Step Therapy** when medications for the Treatment of any Covered Injury or Covered Sickness are restricted for use by a step therapy protocol, the prescribing Physician may request an override of the restriction from Us. An override of that restriction will be granted by Us when the Physician provides all necessary information to perform the override review. The information required is listed below.
   a. The prescribing Physician can demonstrate, based on sound clinical evidence, that the preferred Treatment required under step therapy protocol has been ineffective in the Treatment of the Insured Person's Covered Injury or Covered Sickness; or
   b. Based on sound clinical evidence or medical and scientific evidence:
      1) The prescribing Physician can demonstrate that the preferred Treatment required under the step therapy protocol is expected or likely to be ineffective based on the known relevant physical or mental characteristics of the Insured Person and known characteristics of the drug regimen; or
      2) The prescribing Physician can demonstrate that the preferred Treatment required under the step therapy protocol will cause or will likely cause an adverse reaction or other physical harm to the Insured Person.

2. **Specialty Prescription Drugs** may be limited access or distribution and are limited to no more than a 30-day supply/subject to supply limits.

   As used in this benefit, Specialty Prescription Drugs are Prescription Drugs which:
   a. Are only approved to treat limited patient populations, indications, or conditions;
   b. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
   c. 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.

3. **Contraceptives** - We will provide coverage for a 12 month supply of contraceptives which may be dispensed all at once or over the course of the 12 months at the discretion of the Provider. We will also provide coverage with no Deductible, Coinsurance, Copayment, or other cost-sharing for at least one drug, device, or other product in each contraceptive method for women identified by the FDA and prescribed by a Physician. See the link for list of contraceptive methods identified by the FDA. https://www.fda.gov/ForConsumers/ByAudience/ForWomen/FreePublications/ucm522453.htm.

4. **Quantity Limits** – Some Outpatient Prescription Drugs are subject to quantity limits. The quantity limits help the prescriber and pharmacist verify that the Outpatient Prescription Drug is used correctly and safely We rely on medical guidelines, FDA-approved recommendations, and other criteria developed by Us to set these quantity limits.

5. **Tier Status** – The tier status of a Prescription Drug may change. Such changes may occur without prior notice to the Insured Person. However, if the Insured Person has a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic Drug) We will notify the Insured Person of the change 90 days before such change. When such changes occur, the out-of-pocket expense may change. The most current tier status is available at www.chpstudenthealth.com or by calling 877-657-5030 the number on the Insured Person's ID card.

6. **Formulary Exception Process** – If a Prescription Drug is not on Our Formulary, the Insured Person, his or her designee, or the prescribing Physician may request a Formulary exception for clinically appropriate Prescription Drug in writing, electronically or telephonically. If coverage is denied under Our standard or expedited Formulary exception process, the Insured Person is entitled to an external appeal as outlined in the External Appeal section of the Policy. Visit Our website www.chpstudenthealth.com or call the number on the Insured Person's ID card to find out more about this process.

Standard Review of a Formulary Exception – We will make a decision and notify the Insured Person, his or her designee, and the prescribing Health Care Professional no later than 72 hours after Our receipt of the Insured Person's request. If We approve the request, We will cover the Prescription Drug while the Insured Person is taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception – If the Insured Person is suffering from a health condition that may seriously jeopardize his or her health, life, ability to regain maximum function, or if the Insured Person is undergoing a current course of Treatment using a Non-Formulary Prescription Drug, he or she may request an expedited review of a Formulary exception. The request should include a statement from the prescribing Physician that harm could reasonably come to the Insured Person if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify the Insured Person, his or her designee, and the prescribing Physician no later than 24 hours after Our receipt of the request. If We approve the request, We will cover the Prescription Drug while the Insured Person suffers from the health condition that may seriously jeopardize his or her health, life or ability to regain maximum function, or for the duration of the Insured Person's current course of treatment using the Non-formulary Prescription Drug.

7. **Supply Limits** – We will pay for no more than a 30-day supply of the Prescription Drug purchased at a retail pharmacy. The Insured Person is responsible for one (1) cost sharing amount for up to a 30-day supply.

EXCLUSIONS

Benefits are not payable for the following medications and Prescription Drugs:

- A drug which does not, by federal or state law, require a prescription order, i.e. over-the-counter drugs, even if a prescription is written;
- a drug which has an over-the-counter equivalent;
- Brand-Name Prescription Drugs with generic equivalents;
- allergy sera and extracts administered via injection;
- weight control drugs;
- fertility drugs;
- vitamins, minerals, food supplements;
- sexual enhancements drugs;
- dietary supplements;
- cosmetic, including but not limited to, the removal of wrinkles or other natural skin blemishes due to aging or physical maturation, or Treatment of acne except as specifically provided in this Rider;
- blood glucose meters, asthma holding chambers and peak flow meters are eligible health services, but are limited to one (1) prescription order per Policy Year;
- refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
- drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental Drugs;
- purchased after the Insured Person's coverage terminates;
- a drug that is consumed or administered at the place where it is dispensed;
- any drug that the FDA determines is: contraindicated for the Treatment of the condition for which the drug was prescribed; or Experimental for any reason;
- bulk chemicals;
- non-insulin syringes, surgical supplies, durable medical equipment/medical devices with the exception of diabetic blood monitors and kits;
- repackaged products;
- blood components;
- single agent opioids;
- immunology products.

All other provisions of the Policy to which this Rider is attached remain the same.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

President

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PRE-CERTIFICATION AND MEDICAL MANAGEMENT RIDER

Pre-certification
The Policy to which this Rider is attached is amended to add the text below to the Description of Benefits section, after Benefit Payments paragraph. This rider is effective on the issue date of the Policy.

Pre-certification means the process of determining Medical Necessity before an Insured Person receives certain Treatments, services, or supplies. The Insured Person must notify the Plan Administrator and gain the Administrator's approval before the Insured Person receives any Treatment, service, or supply listed in this rider. Pre-certification is not a guarantee the Treatment, service, or supply is an Eligible Expense under the Policy. Pre-certification is not required for Emergency Services.

Pre-Certification Process
The Insured Person is responsible for notifying the claims administrator at the phone number found on the Insured Person's ID card to begin the Pre-certification process. For inpatient benefits or surgery, the call must be made at least 5 working days before Hospital Confinement or surgery.

The following inpatient benefits require Pre-certification:
1. All inpatient admissions to a Hospital, Skilled Nursing Facility, facility established primarily for the Treatment of Substance Use Disorder, or residential Treatment facility. The expected length of stay should be included in the notification;
2. All inpatient maternity care after the initial 48/96 hours;
3. Surgery.

Pre-certification is not required for:
- Medical Emergency or Urgent Care;
- Hospital Confinement for maternity care; or
- Obstetric or gynecological care when provided by a Network Provider; or
- Outpatient treatment.

Pre-certification does not guarantee that Benefits will be paid.

The Insured Person's Physician will be notified of Our decision as follows:
1. For non-urgent admissions to a health care facility, We will notify the Physician and the health care facility by telephone and/or in writing of the approved number of inpatient days;
2. For confinement in a health care facility longer than the originally approved number of days, the treating Physician or the health care facility must contact the claims administrator before the last approved day. We will review the request for continued stay to determine Medical Necessity and notify the Physician or the health care facility of Our decision in writing or by telephone;
3. For any other covered services for which We require Pre-certification, We will contact the Physician in writing or by telephone regarding Our decision.

For an urgent request, Our claims administrator will make the determination within twenty-four (24) hours after receipt of all necessary information for review. For non-urgent requests, Our claims administrator will make the determination within seventy-two (72) hours after receipt of all necessary information for review. Notice of an Adverse Determination made by Our claims administrator will be in writing and will include:
1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.

3. Notice of the availability, upon request of the Insured Person or his or her designee, of the clinical review criteria relied upon to make the Adverse Determination. The notice will specify any additional information needed by Our claims administrator to reach a decision on an appeal.

Failure by the claims administrator to make a determination within the time periods prescribed shall be deemed an Adverse Determination subject to an appeal.

The Insured Person should contact his or her Physician with questions about any Pre-certification status.

Medical Management
The benefits described in this Policy are subject to pre-certification, concurrent review, and discharge planning. The purpose of the reviews is to determine which services are Covered Medical Expenses and to assist in determining the most cost-effective methods of providing medical care. Such reviews may include analysis of procedures and the setting of where the service is performed.

Concurrent Review means review conducted during the Insured Person's stay or course of treatment in a facility, the office of a Physician, or other inpatient or outpatient health care setting.

Discharge planning means the process for determining, prior to discharge from a Hospital, the coordination and management of the care an Insured Person receives following discharge from the Hospital.

All other provisions of the Policy remain unchanged.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY

President

NGL Insurance Group Privacy Notice
National Guardian Life Insurance Company
Settlers Life Insurance Company

The listed companies of the NGL Insurance Group (or "NGL") are committed to protecting the privacy of the personal information we receive ("Information") about you. By choosing to do business with us, you have placed your trust in us and we take this responsibility very seriously. This notice states our privacy practices. Our pledge to you is "your privacy is our priority."

Why We Collect and How We Use Information:

When you apply to any of our insurance companies for any product or service, you disclose to us a certain amount of Information about yourself. We collect only Information necessary or relevant to our business. We use the Information to evaluate, process and service your request for products and services and to offer you other NGL products or services.

Types of Information We Collect:

We collect most Information directly from you on applications or from other communications with you during the application process.

Types of Information we could collect include, but are not limited to:

- name
- address
- age
- social security number
- beneficiary information
- other insurance coverage
- health information
- financial information
- occupation
- hobbies
- other personal characteristics

We also may keep Information about your transactions with us:

- types of products you buy
- your premium amount
- your account balances
- your payment history

Additional Information is received from:

- medical personnel
- medical institutions
- Medical Information Bureau (MIB, Inc.)
- other insurance companies
- agents
- employers
- public records
- consumer reporting agencies

How We Disclose Your Information:

Your Information as described above may be disclosed as permitted by law to our affiliates and nonaffiliated third parties. These disclosures include, but are not limited to the following purposes:

- To assess eligibility for insurance, benefits or payments
- To process and service your requests for our products and services
- To collect premium, pay benefits and perform other claims administration
- To print and mail communications from us such as policy statements
- For audit or research purposes
- To respond to requests from law enforcement authorities or other government authority as required by law
- To resolve grievances
- To find or prevent criminal activity, fraud, material misrepresentation or nondisclosure in connection with an insurance issue

NGL also may disclose your Information as permitted by law to our affiliates without prior authorization in order to offer you other NGL products or services. The law does not allow you to restrict such disclosures.

Except for the above disclosures or as authorized by you with respect to your Information, NGL does not share Information about our customers or former customers with nonaffiliated third parties. Further, when Information is disclosed to any nonaffiliated third parties as permitted by law, we require that they agree to our privacy standards. Please note that Information we get from a report prepared by an insurance support organization may be retained by that insurance support organization and used for other purposes.

Access to and Correction of Your Information:

You have the right to access and correct your Information that we have on file. Generally, upon your written request, we will make your Information available for your review. Information collected in connection with or in anticipation of a claim or legal proceeding need not be disclosed to you.

If you notify us that your Information should be corrected, amended or deleted, we will review it. We will either make the requested change or explain our refusal to do so. If we do not make the requested change, you may submit a short written statement of dispute, which we will include in any future disclosure of Information. For a more detailed explanation of these rights to access and correction, please send us a written request.

Massachusetts Policyholders: You will be notified in writing of any adverse underwriting decisions, including the specific reason the adverse decision was made.

How We Protect Your Information:

NGL has developed strong security measures to guard the Information of our customers.

We restrict access to your Information to designated personnel or service providers who administer or offer our products or services, or who may be responsible for maintaining Information security practices.

We maintain physical, electronic and procedural safeguards that comply with applicable laws to protect your Information.

Please keep a copy of this notice with your important papers. Additional copies of this notice are available upon written or verbal request. This notice is also available on NGL's website, www.nglic.com.

National Guardian Life Insurance Company
Commercial Travelers Life Insurance Company

JOINT NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Commercial Travelers Life Insurance Company and National Guardian Life Insurance Company are required by law to maintain the privacy of your health information and to provide you with notice of their legal duties and privacy practices with respect to your health information.

How We May Use or Disclose Your Health Information

1. **Payment Functions.** We may use or disclose health information about you to determine eligibility for plan benefits, obtain premiums, facilitate payment for the treatment and services you receive from health care providers, determine plan responsibility for benefits, and to coordinate benefits.

2. **Health Care Operations.** We may use and disclose health information about you to carry out necessary insurance-related activities, including, but not limited to, underwriting, premium rating and other activities relating to plan coverage; conducting quality assessment and improvement activities; submitting claims for stop-loss coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs.

3. **Required by Law.** As required by law, we may use and disclose your health information. We may disclose medical information pursuant to a court order in judicial or administrative proceedings; to report information related to victims of abuse, neglect, or domestic violence; or to assist law enforcement officials in their law enforcement duties.

4. **Public Health.** As required by law, we may disclose your health information to public health authorities to prevent or control disease, injury or disability, or for other health oversight activities.

5. **Coroners, Medical Examiners and Funeral Directors.** We may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person.

6. **Organ and Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.

7. **Health and Safety.** We may disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

8. **Government Functions.** We may disclose your health information for military, national security, prisoner and government benefits purposes.

9. **Worker's Compensation.** We may disclose your health information as necessary to comply with worker's compensation or similar laws.

10. **Disclosures to Plan Sponsors.** We may disclose your health information to the sponsor of your group health plan for purposes of administering benefits under the plan.

When We May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, we will not use or disclose your health information without written authorization from you. If you do authorize us to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

Statement of Your Health Information Rights

1. **Right to Request Restrictions.** You have the right to request restrictions on certain uses and disclosures of your health information. We are not required to agree to the restrictions that you request.

2. **Right to Request Confidential Communications.** You have the right to receive your health information through alternative means or at an alternative location. We are not required to agree to your request.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information. If you request a copy of the information, we may charge you a reasonable fee to cover the copy expense.

4. **Right to Request a Correction.** You have a right to request that we amend your health information. We are not required to change your health information.

5. **Right to Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information. We will provide one list per 12 month period free of charge; we may charge you for any additional lists requested within the same 12 month period.

6. **Right to Paper Copy.** You have a right to receive a paper copy of this Notice of Privacy Practices at any time.

7. **Right to Revoke Permission.** You have the right to revoke your authorization to use or disclose your health information at any time, except to the extent that action has already been taken.

Our Obligations Under This Notice

We are required by law to:

1. Maintain the privacy of your health information.

2. Provide you with a notice of our legal duties and privacy practices with respect to your health information.

3. Abide by the terms of this Notice.

4. Provide you notice of a breach of any unsecured personal health information.

5. Notify you if we are unable to agree to a requested restriction on how your information is used or disclosed.

6. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

7. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law, including psychotherapy notes, personal health information for marketing purposes, and information in instances constituting the sale of personal health information.

We reserve the right to amend this Notice of Privacy Practices at any time in the future and to make the new Notice provisions effective for all health information that we maintain. Revised Notices will be distributed to you by mail.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with:

Privacy Officer
Commercial Travelers Life Insurance Company
70 Genesee Street
Utica, NY 13502

You may also file a complaint with the Secretary of the Department of Health and Human Services. We will not retaliate against you in any way for filing a complaint.

Effective Date of This Notice: June 12, 2017

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APPLICATION FOR STUDENT ACCIDENT AND SICKNESS INSURANCE

1. Name of School, College or University: Champlain College

   Address: Burlington, VT

2. Plan of Benefits:

   ❑ Same as current year's program, except _____

   ❑ In accordance with proposal dated _____, _____

   ☒ Other In accordance with attached Policy No. 2018I5A07 and all attachments hereto.

   Do you wish to provide coverage for the following optional benefits:
   List Optional Benefits Here:

   Adult Vision Care ☐ Yes ☒ No

3. Premium Rates:

	Annual	**Fall**	**Spring/Summer**
Student:	$1,747.00	$694.00	$1,053.00

4. Terms of coverage, from: August 9, 2018 To: August 9, 2019

Any policy issued by National Guardian Life Insurance Company in consideration of this Application and payment of the first premium will include only those benefits shown in the proposal and agreed to by Us and the Applicant.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive and insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

_____	_____	_____
Signature of School Official	Position or Title	Date

Agent/Broker Name: _____

Address: _____

_____

Tax I.D./Social Security Number: _____