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: Commercial Travelers Mutual Insurance Company
70 Genesee Street
Utica, NY 13502-3502
800-756-3702

STUDENT BLANKET 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

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INSURANCE INFORMATION SCHEDULE

POLICYHOLDER: Saint Xavier University
Chicago, IL

POLICY NUMBER: 2016A5A00

EFFECTIVE DATE: August 11, 2016

TERMINATION DATE: August 10, 2017

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	$1,792.00
Student Only	Spring/Summer	$1,065.00
Student Only	Summer	$ 610.00

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

STUDENT CLASSIFICATION

☒ Domestic ☒ International ☒ Scholar □ Other (Specify)

PARTICIPATION

☒ Voluntary – Grad Student ☒ Waiver – Undergraduate Student □ Mandatory □ Other (Specify)

SCHEDULE OF BENEFITS
GOLD PLAN

Benefit Period: When an Insured Person receives initial medical treatment within 60 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 Usual and Reasonable charge 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 50% of the Usual and Reasonable charge.

Deductible:

Network	$500.00
Non-Network	$500.00

Out-of-Pocket Expense Limit:

Network Provider	Individual - $6,250.00
Non-Network Provider	Individual - $6,250.00

Coinsurance Amount:

Network Provider:	80% of PPO Allowance for Covered Medical Expenses unless otherwise stated below.
Non-Network Provider:	50% 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 and Non-Network Providers. Different benefits may be payable for Covered Medical Expenses rendered by Network Providers versus Non-Network Providers.

PREFERRED PROVIDER ORGANIZATION:
To locate a PHCS Provider in Your area, consult Your Provider Directory or visit the network website at www.StXavierInsurance.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	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Hospital Intensive Care Unit Expense - in lieu of normal Hospital Room & Board Expenses	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
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	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Preadmission Testing	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Physician's Visits while Confined	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Surgery: Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Registered Nurse Services for private duty nursing while confined	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Skilled Nursing Facility Expense Benefit	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Benefit	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Substance Use Disorder Benefit	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Benefits		
Outpatient Surgery: Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	30% of benefits payable for Surgeon Services	30% of benefits payable for Surgeon Services
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses

BENEFITS PER COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Outpatient Benefits (continued)		
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	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
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 Cardiac Rehabilitation services limited to 36 treatment sessions per Policy Year	80% of PPO Allowance for Covered Medical Expenses Copayment: $40.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40.00
Emergency Services Expenses Emergency medical care because of a criminal sexual assault or abuse – no cost sharing	80% of PPO Allowance for Covered Medical Expenses Copayment: $500.00	80% of PPO Allowance for Covered Medical Expenses Copayment: $500.00
In Office Physician's Visits	80% of PPO Allowance for Covered Medical Expenses Copayment: $40.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40.00
Mental Health Disorder	80% of PPO Allowance for Covered Medical Expenses Copayment: $40.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40.00
Substance Use Disorder	80% of PPO Allowance for Covered Medical Expenses Copayment: $40.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40.00
Urgent Care Centers or Facilities	80% of PPO Allowance for Covered Medical Expenses Copayment: $40.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40.00
Diagnostic X-ray Services	80% of PPO Allowance for Covered Medical Expenses Copayment: $25.00	80% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25.00
Laboratory Procedures (Outpatient)	80% of PPO Allowance for Covered Medical Expenses Copayment: $25.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25.00
Allergy Testing and Treatment Benefit	80% of PPO Allowance for Covered Medical Expenses Copayment: $40.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40.00
Prescription Drugs	Generic Copayment: $25.00 Preferred Brand Copayment: $45.00 Brand Copayment: $60.00 See Prescription Card	N/A
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses

BENEFITS PER COVERED INJURY/SICKNESS	IN-NETWORK	NON-NETWORK
Outpatient Benefits (continued)		
Home Health Care Expenses	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Hospice Care Coverage	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Private Duty Nursing	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Chiropractic Care	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Other Benefits		
Ambulance Service	80% of PPO Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses
Braces and Appliances	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Durable Medical Equipment	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Maternity Benefit	Same as any other Covered Sickness	Same as any other Covered Sickness
Routine Newborn Care	Same as any other Covered Sickness	Same as any other Covered Sickness
Consultant Physician Services	80% of PPO Allowance for Covered Medical Expenses Copayment: $40.00	50% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $40.00
Additional Surgical Opinion upon request by Insured Person	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Accidental Injury Dental Treatment for Insured Persons over age 18	80% of PPO Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses
Pediatric Dental Care Benefit Preventive Dental Care - limited to 1 dental exam every 6 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 50% of the Usual and Reasonable Charge for Preventive Services
Emergency Dental	50% Usual and Reasonable	50% Usual and Reasonable
Clinical Oral Evaluations	50% Usual and Reasonable	50% Usual and Reasonable
Endodontic Services	50% Usual and Reasonable	50% Usual and Reasonable
Periodontal 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 Limited to 1 visit(s) per Policy Year and 1 pair of prescribed lenses and frames	100% of PPO Allowance for Preventive Services	50% of Usual and Reasonable Charge for Covered Medical Expenses
Naprapathic Service Up to $1,000.00 per Policy Year	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Non-Emergency Treatment outside the United States	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses
Hearing Aid Benefit	80% of PPO Allowance for Covered Medical Expenses	50% of Usual and Reasonable Charge for Covered Medical Expenses

MANDATED BENEFITS		
BENEFITS PER COVERED INJURY/SICKNESS	**IN-NETWORK**	**NON-NETWORK**
Habilitative Services for Children	Same as any other Habilitative Service	
Human Papillomavirus Vaccine Benefit	Same as any other Preventive Service	
Shingles Vaccine For Insureds age 60 or older	Same as any other Preventive Service	
Infertility Treatment Up to 4 treatments Additional 2 treatments following a live birth	Same as any other Covered Sickness	
Post-Mastectomy Care	Same as any other Covered Sickness	
Reconstructive Breast Surgery	Same as any other Surgical benefit	
Routine Care During Clinical Cancer Trials Benefit	Same as any other Covered Sickness	
Amino Acid-based Elemental Formula Benefit	Same as any other Covered Sickness	
Adjunctive Services in Dental Care Benefit	Same as any other Covered Sickness	
Breast Cancer Pain Medication and Therapy Benefit	Same as any other Prescription Drug	
Multiple Sclerosis Preventive Physical Therapy Benefit	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. **Voluntary Participation -** All individuals shown on the Insurance Information Schedule are eligible for Accident and Sickness insurance on a Voluntary Participation basis.

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

3. **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.

Voluntary Participation means that only those eligible persons who have:
1. Executed Our enrollment form; and
2. Paid the required premium

are insured under this Policy.
A Voluntary Program is one in which the parent(s), guardian, or student pays the premium for this Policy. This Policy will cover at least the first $100 of eligible expenses incurred. We will provide notice to the premium payer that after the first $100 in benefits have been paid, We will continue to pay benefits only if no other coverage is in effect. If there is other coverage, claims for benefits in excess of the first $100 must be filed under the other coverage until those benefits have been exhausted. We are responsible for the amount over what the other coverage paid. We will pay benefits on those services as described in the Schedule of Benefits and Description of Benefits section of this Policy.

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.

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

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

No other refunds will be allowed.

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 or scholars, the date the Insured Person departs his or her Home Country to travel to the Country of Assignment. The scheduled arrival in the Country of Assignment must be no more than 48 hours later than the departure from the Home Country.

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.

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 31 days. This includes the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities from the moment of birth.

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 90 days from the Termination Date while such confinement continues.

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

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

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

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

Covered Injury means a bodily injury that is:
1. Sustained by an Insured Person while he/she is insured under this Policy or the School's prior policies; and
2. Caused by an accident.

Coverage under the School's policies must have remained continuously in force:
1. From the date of Injury; and
2. Until the date services or supplies are received,

for them to be considered as a Covered Medical Expense under this Policy.

Covered Medical Expense means those charges that are:
1. Not in excess of the PPO Allowance for any Medically Necessary treatment, service, or supplies that are received from Network Providers;
2. Not in excess of the Usual and Reasonable charges for any Medically Necessary treatment, service, or supplies are received from Non-Network providers;
3. Not in excess of the charges that would have been made in the absence of this insurance;
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 Treatment includes, but is not limited to, treatment for acne, warts and moles removed for cosmetic purposes, weight reduction, learning disabilities, routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

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

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

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

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

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 expenses that an Insured Person is responsible for paying.

Physician means a:
a. 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.); or
7. Doctor of Naprapathy (D.N);

who is licensed to practice as such by the governmental authority having jurisdiction over the licensing of such classification of doctor in the state where the service is rendered.

A Doctor of Psychology (Ph.D.) will also be considered a Physician when he or she is similarly licensed or licensed as a Health Care Provider. The services of a Doctor of Psychology must be prescribed by a Doctor of Medicine.

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a certified nurse practitioner, a certified nurse-midwife, a Physician's assistant, social workers and psychiatric nurses to the same extent that their services would be covered if performed by a Physician.

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.

Private Duty Nursing Services means services that cannot be provided by non-professional personnel and can only be provided by a licensed health care provider. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers.

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

Skilled Nursing Facility means an institution that provides skilled nursing care under the supervision of a Physician, provides 24-hour nursing service by or under the supervision of a registered nurse (R.N.) and maintains a daily record of each patient. Skilled nursing facilities must be licensed by an appropriate state agency and approved for payment of Medicare benefits to be eligible for reimbursement.

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.

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 - STUDENT HEALTH CENTER REFERRAL

This is a supplemental plan. Where available, the student must first use the resources of the Student Health Center (SHC) where treatment will be administered or a referral issued. Expenses incurred for medical treatment rendered outside of the SHC for which no prior approval or referral is obtained may be excluded from coverage. A referral issued by the SHC must accompany the claim when submitted.

A SHC referral for outside care is not necessary **ONLY** under the following conditions:
a. For an Emergency Medical Condition. The student must return to the SHC for necessary follow-up care;
b. When the SHC is closed;
c. For medical care received when the student is more than 20 miles from campus;
d. For medical care obtained when a student is no longer able to use the SHC due to a change in student status.
e. For maternity care;
f. When service is rendered at another facility during break or vacation period;
g. Psychiatric services.

SECTION VI - DESCRIPTION OF BENEFITS

Benefit Payments

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 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. This benefit will continue to be paid for the Emergency Services until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will be reduced and paid at the lower percentage applicable to a Non-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 the service.

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.

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.

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. If the Insured Person uses a Network Provider, any Coinsurance, Deductible, or Copayment will be included in the Network Out-of-Pocket Expense Limit. If the Insured Person uses a Non-Network Provider, any Coinsurance, Deductible, or Copayment will be included in the Non-Network 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 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. 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 pay a benefit equal to the benefit payable for the procedure with highest benefit value. This benefit is not payable in addition to Physician's visits.

   Benefits for human organ transplants are payable on the same basis as other inpatient surgery. We will not deny benefits for experimental or investigational organ transplants unless they have been deemed as such by determination of the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within the federal Department of Health and Human Services (Office of HCTA). If there is a question of whether an organ transplant is experimental or investigational, We will make a request for a determination by the Office of HCTA. If the Office of HCTA fails to respond to the request within 90 days, the failure of the Office of HCTA to respond will be deemed a determination that the procedure is experimental or investigational and benefits will not be payable for the transplant.

   Benefits are available for only the transplantation of the following human organs or tissues:
   a. Cornea
   b. Kidney
   c. Bone marrow
   d. Heart valve
   e. Muscular-skeletal
   f. Parathyroid
   g. Heart
   h. Lung
   i. Heart/lung
   j. Liver
   k. Pancreas
   l. Pancreas/kidney

   Benefits for transportation and lodging are limited to a combined maximum of $10,000.00 per transplant. The maximum benefit per day for lodging is $50.00. Benefits are available for the transportation of the donor organ in the United States or Canada only.

Benefits are available to the recipient and donor as follows:

- If donor and recipient both have coverage provided by Us, each will have benefits paid by his or her own plan.
- If the Insured person is the recipient and the donor has no coverage from any other source, benefits under this Policy will be paid for the Insured and the donor.
- If the Insured Person is the donor and no coverage is available to the Insured Person from any other source, the benefits under this Policy will be provided to the Insured Person. No benefits will be provided to the recipient.

Covered services include:

- Inpatient and outpatient services related to the transplant surgery.
- Evaluation, preparation, and delivery of the donor organ.
- Removal of the organ from the donor.
- Transportation of the organ to the location of the transplant surgery.
- Human organ transplants provided by Non-network Providers are not eligible for benefits.

7. **Registered Nurse's Services** when private duty nursing care is prescribed by the attending Physician. General nursing care provided by the Hospital is not covered under this benefit.

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

9. **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.

10. **Mental Health Disorder Benefit** for inpatient treatment of Mental Health Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

11. **Substance Use Disorder Benefit** for inpatient treatment of Substance Use Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

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 pay a benefit equal to the benefit payable for the procedure with highest benefit value.

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 o**nly 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. 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. **Mental Health Disorder Benefit** for outpatient treatment of Mental Health Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

7. **Substance Use Disorder Benefit** for outpatient treatment of Substance Use Disorders on the same basis as any other Covered Sickness. See Treatment of Covered Injury or Covered Sickness.

8. **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.

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

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

11. **Allergy Testing and Treatment Benefit** for evaluations and testing including injections, scratch and prick tests, to determine the existence of an allergy. This benefit includes allergy treatment, including desensitization treatment, routine allergy injections, and serums. Allergy treatment will be paid under this benefit and not the Prescription Drug Benefit.

12. **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. Contraceptive Coverage for all Outpatient Contraceptive Services, drugs, and devices approved by the Food and Drug Administration (FDA). For the purpose of this benefit, **Outpatient Contraceptive Services** means consultations, examinations, procedures, and medical services related to the use of contraceptive methods, including natural planning, to prevent unintended pregnancy when provided on an outpatient basis. Contraceptive coverage is payable on the same basis as other Prescription Drug coverage.
    b. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
        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.
    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.

13. **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.

14. **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. The Insured Person must be unable to leave home without assistance and require supportive devices or special transportation and require intermittent Skilled Nursing Services under the direction of the Insured Person's Physician. Benefit includes coverage for:
    a. skilled nursing service by a registered professional nurse;
    b. Services of physical, occupational, or speech therapists;
    c. occupational and speech therapists; and
    d. hospital laboratories and necessary medical supplies.

    The Home Health Care Expense benefit does not include coverage for Private Duty Nursing or services for activities of daily living such as personal hygiene, cleaning, or cooking.

15. **Hospice Care Coverage w**hen, 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 and the medical prognosis must a life expectancy of one year or less. 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.
    Covered services include:
    a. Coordinated home care;
    b. Medical supplies and dressings;
    c. Medication;
    d. Nursing services, both skilled and non-skilled;
    e. Occupational therapy;
    f. Physical therapy;
    g. Physician visits;
    h. Social and spiritual services; and
    i. Respite care service.

    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.

16. **Private-Duty Nursing Services** when provided to the Insured Person while confined to his or her home. This benefit is not intended to provide for long term supportive care. No benefit will be provided for services by a nurse who resides in the Insured Person's home or who is a member of the Insured Person's immediate family.

17. **Chiropractic Care Benefit** for treatment of a Covered Injury or Covered Sickness when performed by a Physician for in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be covered in accordance with the terms and conditions of this Policy.

Other Benefits

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

2. **Braces and Appliances** 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. **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.

4. **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.

5. **Routine Newborn Care -** when expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:
   a. Charges made by a Hospital for routine well baby nursery care when there is a distinct charge separate from the charges for the mother;
   b. Inpatient Physician visits for routine examinations and evaluations;
   c. Charges made by a Physician in connection with a circumcision;
   d. Routine laboratory tests;
   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 up to $200.00.

6. **Consultant Physician Services** when requested and approved by the attending Physician.

7. **Additional Surgical Opinion** requested by the Insured Person for one consultation and diagnosis by a Physician regarding a recommendation by a different Physician for elective surgery. We will pay 100% of the consultation and diagnosis fee by the Physician providing the additional opinion, regardless of whether the Physician is a Preferred Provider, subject to all applicable cost sharing. This benefit is available when the Insured Person's opinion regarding the necessity of the surgery is not resolved by the first consultation with a Physician.

8. **Accidental Injury Dental Treatment** that is required as the result of Injury. Routine dental care and treatment are not payable under this benefit..

9. **Pediatric Dental Care Benefit** for the following dental care services for Insured Persons up to age 19.
   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).

10. **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 and eyeglass frames every Policy Year.

11. **Naprapathic Services** when performed by a licensed Naprapath. Massage therapists are not eligible providers of naprapathic services.

12. **Non-Emergency Treatment outside the United States** for covered Medical Expenses received when the Insured Person is traveling outside the United States.

13. **Oral Surgery/Temporomandibular Joint Dysfunction (TMJ) Benefit** for only the following procedures:
    a. surgical removal of complete bony impacted teeth;
    b. excision of tumors or cysts of the jaws, checks, lips, tongue, roof and floor of the mouth;
    c. surgical procedures to correct accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    d. excision of exostoses of the jaws and hard palate (except when performed in preparation for dentures or other prostheses);
    e. treatment of fractures of facial bones;
    f. external incision and drainage of cellulitis;
    g. incision of accessory sinuses, salivary glands, or ducts; and
    h. reduction of dislocation of, or excision of the temporomandibular joints.

14. **Hearing Aid Benefit** for expenses incurred for bone-anchored hearing aids (osseointegrated auditory implants). This benefit does not include hearing examinations or fitting of hearing aids.

Mandated Benefits for Illinois

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.

Habilitative Services for Children under 19 years of age with congenital, genetic, or early acquired disorder if each of the following are true:
1. A Physician has diagnosed the disorder.
2. Treatment is administered by a Physician.
3. The treatment is not experimental or investigational.

Upon request from Us, the Physician shall provide medical records, clinical notes, or other necessary data to allow us to substantiate that initial or continued medical treatment is necessary and the Insured Child's condition is clinically improving. We may request a treatment plan consisting of diagnosis, proposed treatment by type, frequency, anticipated durations of treatment, anticipated goals, and frequency of updates to the treatment plan.

We will not pay benefits for services that are solely educational in nature.

As used in this benefit, the following definitions apply:

Habilitative Services means occupational therapy, physical therapy, speech therapy and other services prescribed by the Insured Child's Physician in relation to a treatment plan to enhance the ability of the Insured Child to function with a congenital, genetic, or early acquired disorder.

Congenital or Genetic Disorder includes, but is not limited to, hereditary disorders.

Early Acquired Disorder means a disorder resulting from illness, trauma, injury, or other event or condition suffered by an Insured Child prior to that Child developing function life skills such as, but not limited to, walking, talking, or self-help skills.

Congenital, Genetic, or Early Acquired Disorders may include, but are not limited to, autism or autism spectrum disorder, cerebral palsy, or other disorders resulting from early childhood illness, trauma, or injury.

Human Papillomavirus Vaccine Benefit for expenses incurred for a human papillomavirus vaccine (HPV) that is approved for marketing by the Federal Food and Drug Administration (FDA).

Shingles Vaccine Benefit for Physician-ordered FDA-approved vaccine for shingles. The Insured Person must be age 60 or older.

Infertility Benefit for diagnosis and treatment of infertility. Coverage includes but is not limited to:

1. in vitro fertilization;
2. uterine embryo lavage;
3. embryo transfer;
4. artificial insemination;
5. gamete intrafallopian tube transfer;
6. zygote intrafallopian tube transfer; and
7. low tubal ovum transfer.

Benefits for in vitro fertilization, gamete intrafallopian tube transfer, or zygote intrafallopian tube transfer are payable only if :

1. the Insured Person has been unable to attain or maintain a viable pregnancy, or sustain a successful pregnancy through reasonable, less costly medically appropriate treatments for which coverage is available through this Policy.
2. the Insured Person has not undergone 4 (four) completed oocyte retrievals, except that if a live birth follows a completed oocyte retrieval, then the Insured Person may have 2 (two) more oocyte retrievals.
3. the procedure is performed at a medical facility that conforms to the guidelines for in vitro treatment by the American College of Obstetrics and Gynecology or the American Fertility Society.

For the purpose of this benefit, "infertility" means the inability to conceive after one year of unprotected sexual intercourse, the inability to conceive after one year of attempts to produce conception, the inability to conceive after the Insured Person is diagnosed with a condition affecting fertility, or the inability to sustain a successful pregnancy.

Post-mastectomy Care for inpatient care following a mastectomy. The Insured Person's attending Physician shall determine the length of time that is Medically Necessary for the Insured Person to continue to receive inpatient care. This benefit includes coverage for a post-discharge Physician office visit or an in-home nurse visit within the first 48 hours after discharge.

Reconstructive Breast Surgery for expenses incurred for prosthetic devices or reconstructive surgery following a mastectomy covered under this Policy. Coverage includes:

1. reconstruction of the breast upon which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment for physical complications at all stages of mastectomy, including lymphedemas.

Care will be determined by the Physician and the Insured Person.

Routine Care During Clinical Cancer Trials Benefit for routine patient care provided to an Insured Person who is participating in a qualified clinical cancer trial on the same basis as routine patient care provided to an Insured Person who is not participating in such program.

Qualified Clinical Cancer Trials (QCCT) must meet the following criteria:

1. the effectiveness of the treatment has not been determined relative to established therapies;
2. the trial is under clinical investigation as part of an approved cancer research trial in phase II, Phase III, or Phase IV of investigation;
3. the trial is:
   a. approved by the FDA; or
   b. approved and funded by the National Institutes of Health, Centers for Disease Control and Prevention, United States Department of Defense, United States Department of Veterans Affairs, or the United States Department of Energy in the form of an investigational new drug application, or a cooperative group or center of any entity described in this item; and
4. the Insured Person's primary care Physician, if any, is involved in the coordination of care.

Routine Patient Care, as used in this benefit, means all health care services provided in the qualified clinical cancer trial that are otherwise generally covered under the Policy if those items or services were not provided in connection with a Qualified Clinical Cancer Trial consistent with the standard of care for the treatment of cancer, including the type and frequency of any diagnostic modality, that a provider typically provides to a cancer patient who is not enrolled in a qualified clinical cancer trial. "Routine Patient Care" does not include:

1. a health care service, item, or drug that is the subject of the QCCT;
2. a health care service, item, or drug provided solely to satisfy data collection and analysis needs for the QCCT that is not used in the direct clinical management of the Insured Person;
3. an investigational drug or device that has not been approved for market by the FDA;
4. transportation, lodging, food, or other expenses for the Insured Person or others that are associated with the travel to or from a facility providing the QCCT;
5. any service, item, or drug customarily provided free of charge to the patient by the sponsors of the QCCT;
6. any service or item, which is listed in the Exclusions and Limitations including
   a. costs of extra treatments, services, tests, or drugs that would not be performed or administered except for the fact that the Insured Person is participating in the QCCT; and
   b. costs of non-health care services that the Insured Person is required to receive as a result of participation in the QCCT.
7. costs for any services, items, or drug that are eligible for reimbursement from a source other than this Policy that provide for third-party payment or prepayment of health or medical expenses, including the sponsor of the QCCT; and
8. costs associated with a QCCT designed exclusively to test toxicity or disease pathophysiology, unless such costs would be covered for an Insured Person who is not enrolled in a QCCT.

Diabetes Management Benefit for expenses incurred for Medically Necessary and Physician prescribed outpatient Diabetes Self-management Training, including medical nutrition education, equipment and supplies for the treatment of Type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus.

Coverage for Diabetes Self-management Training, including medical nutrition education, is limited to:

1. Up to three (3) Medically Necessary visits to a qualified provider upon initial diagnosis of diabetes by the Insured Person's Physician; and
2. Up to two (2) Medically Necessary visits to a qualified provider upon a determination by an Insured Person's Physician that a Significant Change in the patient's symptoms or medical condition has occurred.

Benefits will be paid as described in the Schedule of Benefits for the following items and services when authorized by a Physician:

1. Diabetes Self-management Training provided as a part of an office visit, group setting, or home visit;
2. Regular foot care exams by a Physician;

3. The following equipment, pharmaceuticals, and supplies when Medically Necessary and prescribed by a Physician:
   a. Insulin;
   b. Syringes and needles;
   c. Test strips for glucose monitors;
   d. FDA approved oral agents for controlling blood sugar;
   e. Glucagon emergency kits;
   f. Blood glucose monitors;
   g. Blood glucose monitors for the legally blind;
   h. Cartridges for the legally blind; and
   i. Lancets and lancing devices.

As used in this benefit:

Diabetes Self-management Training means instruction in an outpatient setting which enables a diabetic Insured Person to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes Self-management Training will include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including Medical Nutrition Therapy and education programs that allow the Insured Person to maintain an A1c level within the range identified in nationally recognized standards of care.

Medical Nutrition Therapy shall have the meaning ascribed to "medical nutrition care" in the Dietetic and Nutrition Services Practice Act.

Significant Change in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a Significant Change in medical condition that would require a significantly different treatment regimen.

Amino Acid-based Elemental Formula Benefit for amino acid-based elemental formulas used for the diagnosis and treatment of eosinophilic disorders and short-bowel syndrome. Such formulas must be Medically Necessary and prescribed by a Physician.

Adjunctive Services in Dental Care Benefit for the cost of services and anesthetics provided in conjunction with dental care provided to an Insured Person in a dental office, oral surgeon's office, Hospital, Ambulatory Surgical Treatment Center, if:

1. the Insured Person is a child age six (6) or under;
2. the Insured Person has a medical condition that requires hospitalization or general anesthesia for dental care; or
3. the Insured Person is Disabled.

In addition, benefits are payable for the cost of services and anesthetics provided by a dentist in conjunction with dental care provided to an Insured Person who is under age 19 and who has been diagnosed with autism spectrum disorder or a Developmental Disorder. The Insured Person is required to make 2 visits to the dental care provider before accessing coverage under this benefit.

As used in this benefit:

Ambulatory Surgical Treatment Center means any institution, place or building devoted primarily to the maintenance and operation of facilities for the performance of surgical procedures or any facility in which a medical or surgical procedure is utilized to terminate a pregnancy, irrespective of whether the facility is devoted primarily to this purpose. Such facility shall not provide beds or other accommodations for the overnight stay of patients; however, facilities devoted exclusively to the treatment of children may provide accommodations and beds for their patients for up to 23 hours following admission. Individual patients shall be discharged in an ambulatory condition without danger to the continued wellbeing of the patients or shall be transferred to a hospital. The term Ambulatory Surgical Treatment Center does not include any of the following:

1. Any institution, place, building or agency required to be licensed pursuant to the "Hospital Licensing Act", approved July 1, 1953, as amended.
2. Any person or institution required to be licensed pursuant to the Nursing Home Care Act, the Specialized Mental Health Rehabilitation Act, or the ID/DD Community Care Act.

3. Hospitals or ambulatory surgical treatment centers maintained by the State or any department or agency thereof, where such department or agency has authority under law to establish and enforce standards for the hospitals or ambulatory surgical treatment centers under its management and control.
4. Hospitals or ambulatory surgical treatment centers maintained by the Federal Government or agencies thereof.
5. Any place, agency, clinic, or practice, public or private, whether organized for profit or not, devoted exclusively to the performance of dental or oral surgical procedures.

Developmental Disability means a disability attributable to an intellectual disability or other related condition, if the related condition meets all of the following conditions:
1. the condition is attributable to cerebral palsy, epilepsy, or other condition, other than Mental Health Disorder, found to be closely related to an intellectual disability because such condition results in impairment of general intellectual functioning or adaptive behavior similar to that of individuals with an intellectual disability and required treatment or services similar to those required for such individuals; for the purpose of this definition, "autism" is considered a related condition;
2. the condition is manifested before the Insured Person reaches age 22;
3. the condition is likely to continue indefinitely; and
4. the condition results in substantial functional limitations in three or more of the following types of major life activity:
    a. self-care;
    b. language;
    c. learning;
    d. mobility;
    e. self-direction; and
    f. capacity for independent living.

Disabled means a person, regardless of age, with a chronic disability if the chronic disability meets the following conditions:
1. the condition is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. the condition is likely to continue;
3. the condition results in substantial functional limitations in one or more of the following areas of major life activity:
    a. Self-care;
    b. Receptive and expressive language;
    c. Learning;
    d. Mobility;
    e. Capacity for independent living; or
    f. Economic self-sufficiency.

Breast Cancer Pain Treatment Benefit for Medically Necessary pain therapy related to the treatment of breast cancer. Benefits for medications for treatment of breast cancer pain are covered by the Prescription Drug benefit.

As used in this benefit, **Pain Therapy** means medically based therapy which includes reasonably defined goals, including but not limited to stabilizing or reducing pain, with periodic evaluations of the efficacy of the Pain Therapy against the goals.

Multiple Sclerosis Preventive Physical Therapy Benefit for medically necessary, Physician-prescribed preventive physical therapy for Insured Persons diagnosed with multiple sclerosis. Such preventive physical therapy must have defined goals, including, but not limited to, sustaining the level of function the Insured Person has achieved. Periodic evaluation of the efficacy of the defined goals is required.

As used in this benefit, **Preventive Physical Therapy** means physical therapy for the purpose of treating parts of the body affected by multiple sclerosis.

SECTION VII - 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.
- preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy.
- routine physical or other examinations where there are no objective indications of impairment of normal health or except as specifically provided under the Policy.
- dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person's Sound, Natural Teeth or as provided by the Pediatric Dental Care Benefit.
- services or supplies not necessary for the medical care of the Insured Person's Injury or Sickness.
- services or supplies in connection with eye examinations, eyeglasses or contact lenses, except those resulting from a covered accidental Injury or as provided by the Pediatric Vision Care Benefit.
- expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- 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.
- loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any Intercollegiate sports.
- loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- 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.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
- expenses for weight increase or reduction, except Medically Necessary bariatric surgery and hair growth or removal unless otherwise specifically covered under the policy.
- expenses for radial keratotomy and services in connection with eye examination, eye glasses or contact lenses, except as required for repair caused by a Covered Injury.
- hearing examinations for the prescription or fitting of hearing aids, except for one inpatient hearing screening for a newborn dependent.
- 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).
- treatment to the teeth, including surgical extractions of teeth and any treatment of Temporomandibular Joint Dysfunction (TMJ) other than a surgical procedure for those covered conditions affecting the upper or lower jawbone or associated bone joints. Such a procedure must be considered Medically Necessary based on the Policy definition of same.
- an Insured Person's:
    - committing or attempting to commit a felony,
    - being engaged in an illegal occupation, or
    - participation in a riot.
- 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.

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

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 within 30 days of receipt of due proof of such Loss. If we fail to pay eligible benefits within 30 days the Insured Person is entitled to interest at 9 percent per annum from the 30th day after receipt of proof of loss to the date of the payment. Interest of less than one dollar will not be paid.

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.

Change of Beneficiary: The right to change of beneficiary is reserved to the insured and the consent of the beneficiary(ies) is not requisite to surrender or assignment of this policy or to any change of beneficiary(ies), or to any changes in this Policy.

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 IX - 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 X – 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.

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 had the right to contact the Illinois Commissioner of Insurance or his or her office at any time.
   Illinois Department of Insurance
   Office of Consumer Health Information
   320 West Washington Street
   4th Floor
   Springfield, Illinois 62767
   866-445-5364 toll free
   866-323-5321 TDD
   217-782-4515 phone
   217-782-5020 fax
   Or
   122 S. Michigan Avenue, 19th Floor
   Chicago, IL 60603
   312-814-2420 phone
   312-814-5416 fax

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 the 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. 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 Illinois Department of Insurance at the following address:
   Office of Consumer Health Information
   320 West Washington Street
   4th Floor
   Springfield, Illinois 62767; 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 Illinois 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 Illinois 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.
   c. 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. For an expedited review: 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 Illinois 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 Illinois Commissioner of Insurance immediately shall assign an independent review organization to conduct the review. Upon receipt of a request for external review, the Illinois 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.

NOTICE OF
PROTECTION PROVIDED BY
ILLINOIS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** description of the Illinois Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Illinois law that determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your member life, annuity or health insurance company becomes financially unable to meet its obligations and is placed into Receivership by the Insurance Department of the state in which the company is domiciled. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Illinois law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association per insolvency are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits*
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurances benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

*The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000, except special rules apply to hospital, medical and surgical insurance benefits for which the maximum amount of protection is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also residency requirements and other limitations under Illinois law.

To learn more about these protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ilhiga.org or contact:

Illinois Life and Health	*Illinois Department of Insurance*
Insurance Guaranty Association	*4th Floor*
1520 Kensington Road, Suite 112	*320 West Washington Street*
Oak Brook, Illinois 60523-2140	*Springfield, Illinois 62767*
(773) 714-8050	(217) 782-4515

Insurance companies and agents are not allowed by Illinois law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Illinois law, then Illinois law will control.

NOTICE

This notice is to advise you that should any complaints arise regarding this insurance, you may contact the Policyholder Service Office:

COMMERCIAL TRAVELERS MUTUAL INSURANCE COMPANY
Policyholder Service Office
70 Genesee Street
Utica, New York 13502
TELEPHONE: 1-800-422-6200

- or -

ILLINOIS DEPARTMENT OF INSURANCE
Consumer Division or Public Services Section
320 W Washington Street
Springfield, Illinois 62767
TELEPHONE: 1-217-782-4515

IL-CN-12

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.

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 Mutual 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 Mutual 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: September 23, 2013.

National Guardian®
Life Insurance Company
It's about people.

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191 • Phone 800-988-082(

APPLICATION FOR STUDENT HEALTH INSURANCE

1. Name of School, College or University Saint Xavier University

   Address: Chicago, Illinois

2. Plan of Benefits:

   x☐ Same as current year's program, except n/a

   ☐ In accordance with proposal dated _____

   ☐ Other _____

[Do you wish to provide coverage for the following optional benefits:

List Optional Benefits Here:

Hospice Care ☐ Yes ☐ No

Breast Cancer – Diagnostic, Outpatient, and Rehabilitative Services ☐ Yes ☐ No

3. Premium: Student: ~~$1,796.00~~ 1,792.00 DA.
   Administration: $ 156.00
   Total Annual Rate: $1,952.00

4. Terms of coverage, from August 11, 2016 Through August 10, 2017

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.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature of School Official | date 6/14/16 | Position or Title Assoc. Bursar

Agent/Broker Name Terese M. Harkins, Associated Insurance Plans International, Inc.

Address 609 N. Pine Street, Suite 201, Burlington, WI 53105

Tax I.D./Social Security Number 36-2727564