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:	National Guardian Life Insurance Company Student Insurance Division Commercial Travelers Life Building 70 Genesee Street Utica, NY 13502 1-800-756-3702

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**	**Knut A. Olson** **President**

Non-Participating

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INSURANCE INFORMATION SCHEDULE

POLICYHOLDER: Rose-Hulman Institute of Technology
Terre Haute, IN

POLICY NUMBER: 2019E2A00

EFFECTIVE DATE: August 25, 2019

TERMINATION DATE: August 25, 2020

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	$1,095.00
Spouse Only	Annual	$1,095.00
Child(ren) Only	Annual	$1,095.00

CLASSES OF PERSONS	ENROLLMENT REQUIREMENTS	ENROLLMENT PERIOD	WAITING PERIOD
New Student	12 or more credit hours	31 Days	0 Days
Continuing Student	12 or more credit hours	31 Days	0 Days
Spouse	Student must be enrolled	31 Days	0 Days
Child	Student must be enrolled	31 Days	0 Days

STUDENT CLASSIFICATION

☒ Domestic ☒ International ☐ Scholar ☐ Other (Specify)

PARTICIPATION

☒ Voluntary - Dependent ☒ Waiver - Student ☐ Mandatory ☐ Other (Specify)

SCHEDULE OF BENEFITS
PLATINUM PLAN

Actuarial Value: 90.85% **Next Lower Metal Level: Gold**

Preventive Services:
The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 100% of Usual and Reasonable charge.

Deductible: $0.00

Out-of-Pocket Expense Limit: Individual - $2,500.00
Family - $5,000.00

Coinsurance Amount: 80% of the Usual and Reasonable charge for Covered Medical Expenses

THE COVERED MEDICAL EXPENSE FOR AN ISSUED POLICY WILL BE:
1. **THOSE LISTED IN THE COVERED MEDICAL EXPENSES PROVISION; AND**
2. **ACCORDING TO THE FOLLOWING SCHEDULE OF BENEFITS.**

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE
Inpatient Benefits	
Hospital Room & Board Expenses	The Coinsurance Amount Stated Above
Hospital Intensive Care Unit Expense - ***in lieu of normal Hospital Room & Board Expenses***	The Coinsurance Amount Stated Above
Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	The Coinsurance Amount Stated Above
Preadmission Testing	The Coinsurance Amount Stated Above
Physician's Visits while Confined	The Coinsurance Amount Stated Above
Inpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 The Coinsurance Amount Stated Above The Coinsurance Amount Stated Above The Coinsurance Amount Stated Above
Registered Nurse Services for private duty nursing while confined	The Coinsurance Amount Stated Above
Physical Therapy (inpatient)	The Coinsurance Amount Stated Above
Skilled Nursing Facility Expense Benefit 90 days per Policy Year	The Coinsurance Amount Stated Above
Extended Care Facility Expense Benefit	The Coinsurance Amount Stated Above
Mental Health Disorder Benefit	Same as any other Covered Sickness
Substance Use Disorder Benefit	Same as any other Covered Sickness

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE
Outpatient Benefits	
Outpatient Surgery: Surgeon Services Anesthetist Assistant Surgeon	 The Coinsurance Amount Stated Above The Coinsurance Amount Stated Above The Coinsurance Amount Stated Above
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, misc. supplies, oxygen, oxygen tent, and blood & plasma	The Coinsurance Amount Stated Above
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy Habilitative Services are covered to the extent that they are Medically Necessary	The Coinsurance Amount Stated Above
Emergency Services Expenses	The Coinsurance Amount Stated Above
In Office Physician's Visits	The Coinsurance Amount Stated Above
Diagnostic X-ray Services	The Coinsurance Amount Stated Above
Laboratory Procedures (Outpatient)	The Coinsurance Amount Stated Above
Prescription Drugs	The Coinsurance Amount Stated Above Subject to $5.00 Generic Copayment Subject to $25.00 Preferred Brand Copayment Subject $50.00 Brand Copayment
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	The Coinsurance Amount Stated Above
Home Health Care Expenses	The Coinsurance Amount Stated Above up to 90 visits per Policy Year
Hospice Care Coverage	The Coinsurance Amount Stated Above
Mental Health Disorder Benefit	Same as any other Covered Sickness
Substance Use Disorder Benefit	Same as any other Covered Sickness
Other Benefits	
Ambulance Service	The Coinsurance Amount Stated Above
Braces and Appliances	The Coinsurance Amount Stated Above
Durable Medical Equipment	The Coinsurance Amount Stated Above
Maternity Benefit	Same as any other Covered Sickness
Routine Newborn Care	Same as any other Covered Sickness
Consultant Physician Services – when requested by the attending physician	The Coinsurance Amount Stated Above
Accidental Injury Dental Treatment for Insured Person's over age 18	Subject to $50.00 per tooth maximum $500.00 per Policy Year
Student Health Center/Infirmary Expense	The Coinsurance Amount Stated Above
Sports Accident Expense - incurred as the result of the play or practice of Intercollegiate sports	The Coinsurance Amount Stated Above up to $600.00 per Accident

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE
Other Benefits ***(continued)***	
Pediatric Dental Care Benefit Preventive Dental Care limited to 1 dental exams every 6 months *The benefit payable amount for the following services is different from the benefit payable amount for Preventive Dental Care:* Emergency Dental Clinical Oral Evaluations Endodontic Services Periodontal Services Prosthodontic Services Medically Necessary Orthodontic Care	See Benefit for limitations The Coinsurance Amount for Preventive Dental Care is 100% of Usual and Reasonable, limited to 1 dental exams every 6 months 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable 50% Usual and Reasonable
Pediatric Vision Care Benefit	100% Usual and Reasonable limited to 1 visit(s) and 1 pair of prescribed lenses and frames per Policy Year
MANDATED BENEFITS	
Diabetes Equipment, Supplies and Service	Same as any other Covered Sickness
Diabetes Self-Management	The Coinsurance Amount Stated Above
Mastectomy, Reconstructive Surgery and Prosthetic Devices	Same as any other Covered Sickness
Mental Illness	Same as any other Covered Sickness
Dental Anesthesia Benefit	The Coinsurance Amount Stated Above

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).

4. **Dependent Coverage -** Eligible individuals may also insure, on a Voluntary Participation Basis, their eligible Dependents. Individuals who enroll their dependents must enroll them within (31) days of the Insured Student's enrollment in the plan with the exception of adopted children or newborn children (see the provision entitled **Dependent Child Coverage)**. They will be enrolled for the same term of coverage for which the Insured Student enrolls. Dependents of an **Eligible International Student** must possess a valid passport and a proper visa (either an F-2, J-2 or M-2 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.

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;
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; or
6. For Freshmen and other new students who are required to be on campus prior to the effective date, coverage is extended, but no earlier than August 1.

Dependent's coverage, under the Voluntary Participation Basis, becomes effective on the later of:

1. The day after the date of postmark when the Enrollment Form is mailed; or
2. The beginning date of the term for which premium has been paid; or
3. The day after the date the required individual Enrollment Form and premium payment are received by Us or Our authorized agent. This applies only when premium payment is made within 31 days of the student's enrollment in the School's insurance plan; or
4. The Policy effective date.

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. To continue coverage beyond this initial 31-day period, the Insured Person must:
1. Notify Us of the birth; and
2. Pay any additional premium.

Adopted Children - Dependent Child Coverage also applies to any child adopted or placed for adoption irrespective of whether the adoption has become final.

We must receive:
1. Notification of a child's placement for adoption within 31 days of the placement; and
2. Any premium required for the child.

We will provide coverage for the child placed for adoption as long as the Insured Person:
1. Has custody of the child;
2. The Insured Student's coverage under this policy remains in effect; and
3. The required premiums are furnished to Us.

As it pertains to this provision:

Child means, in connection with an adoption or place for adoption, an individual who has not attained the age of 18 as of the date of the adoption or placement for adoption.

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

Handicapped Children: If:
1. There is dependent coverage; and
2. The Policy provides that coverage of a dependent child will terminate upon attainment of a specified age.

We will not terminate the coverage of such child due attainment of that age while the child is and continues to be both:
1. Incapable of self-sustaining employment by reason of developmental disability or physical handicap; and
2. Chiefly dependent upon the Insured Student for support and maintenance.

Proof of such incapacity and dependence shall be furnished to us within thirty-one days of the child's attainment of the limiting age. Upon request, We may require proof satisfactory to it of the continuance of such incapacity and dependency. We may not request this more frequently than annually after the two-year period following the child's attainment of the limiting age.

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 external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

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

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

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 caused by an Accident directly and independently of all other causes. Coverage under the School's policies must be inforce on the date the services and supplies are received for them to be considered as a Covered Medical Expense.

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

Covered Sickness means 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.

Dependent means:
1. An Insured Student's lawful spouse or lawful Domestic Partner;
2. An Insured Student's dependent biological, adopted child, stepchild, or child subject to the Insured Student's legal guardianship under age 26; and
3. An Insured Student's unmarried biological, adopted child, stepchild, or child subject to the Insured Student's legal guardianship who has reached age 26 and who is:
   a. primarily dependent upon the Insured Student for support and maintenance; and
   b. incapable of self-sustaining employment by reason of mental retardation, mental illness or disorder or physical handicap.
   Proof of the child's incapacity or dependency must be furnished to Us for an already enrolled child who reaches the age limitation, or when a Insured Student enrolls a new disabled child under the plan.

Elective Surgery or Elective Treatment means surgery or medical treatment that is:
1. not necessitated by a pathological or traumatic change in the function or structure of any part of the body; and
2. which occurs after the Insured Person's effective date of coverage.

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

Extended Care Facility means a licensed institution devoted to providing medical, nursing, or custodial care for an Insured Person over a prolonged period, such as during the course of a chronic disease or the rehabilitation phase after an acute sickness or injury.

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.

Out-of-pocket Expense Limit means the amount of Usual and Reasonable expenses that an Insured Person is responsible for paying.

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

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

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

Physician will also means any licensed practitioner of the healing arts who We are required by law to recognize as a "Physician." This includes an acupuncturist, a 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.

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

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

Skilled Nursing Facility means a facility, licensed, and operated as set forth in applicable state law, which:
1. mainly provides inpatient care and treatment for persons who are recovering from an illness or injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time Registered Nurse;
4. is not a place primarily for the care of the aged, Custodial or Domiciliary Care, or treatment of alcohol or drug dependency; and
5. is not a rest, educational, or custodial facility or similar place.

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

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

Student Health Center or Student Infirmary means an on campus facility that provides:
1. Medical care and treatment to Sick or Injury students; and
2. Nursing services.

A Student Health Center or Student Infirmary does not include:
1. Medical, diagnostic and treatment facilities with major surgical facilities on its premises or available on a pre-arranged basis; or
2. Inpatient care.

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

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

Usual and Reasonable means the normal charge, in the absence of insurance, of the provider for a service or supply, but not more than the prevailing charge in the area for a:
1. Like service by a provider with similar training or experience; or
2. Supply that is identical or substantially equivalent.

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

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

SECTION V - DESCRIPTION OF BENEFITS

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; and
5. The Maximum Out-of-Pocket Expense Limit.

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.

Out-of-Pocket Expense Limit
The Out-of-Pocket Expense Limit is shown in the Schedule of Benefits. It provides a cap on the amount of Covered Medical Expenses an Insured Person has to pay. Expenses that are not eligible or amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person's Coinsurance amounts, Deductibles and Copayments will apply toward the Out-of-Pocket Expense Limit.

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

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

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

Covered Medical Expenses

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

Inpatient Benefits

1. **Hospital Room and Board Expense,** including general nursing care. Benefit may not exceed the lesser of the daily semi-private room rate or the amount listed.

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

3. **Hospital Miscellaneous Expenses,** while Hospital Confined or as a precondition for being Hospital Confined. Benefits will be paid for services and supplies such as:
   a. The cost for use of an operating room;

b. Prescribed medicines;
c. Laboratory tests;
d. Therapeutic services;
e. X-ray examinations;
f. Casts and temporary surgical appliances;
g. Oxygen, oxygen tent;
h. Blood and blood plasma; and
i. Miscellaneous supplies.

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

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

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. **Extended Care Facility Expense Benefit** for the services, supplies and treatments rendered to an Insured Person by an Extended Care Facility. The Insured Person must enter an Extended Care Facility:
    a. Within seven (7) days after his/her discharge from a Hospital confinement;
    b. Such confinement must be of at least three (3) consecutive days that began while coverage was in force under this Policy; and
    c. Was for the same or related Sickness or Accident;

    Services, supplies and treatments by an Extended Care Facility include:
    a. Charges for room, board, and general nursing services
    b. Charges for physical, occupational, or speech therapy;
    c. Charges for drugs, biologicals, supplies, appliances, and equipment for use in such facility, which are ordinarily furnished by the Extended Care Facility for the care treatment of a confined person; and
    d. Charges for medical services of interns, in training, under a teaching program of a Hospital with which the facility has an agreement for such services.

11. **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.

12. **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** only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, surgical center or clinic. Payment of this benefit will not be denied based on the final diagnosis following stabilization.

5. **In Office Physician's Visits** for Physician's office visits. We will not pay for more than one visit per day. 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. **Diagnostic X-ray Services** for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a Physician.

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

8. **Prescription Drugs** for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication necessary for the treatment of the Covered Injury or Covered Sickness for which a claim is made.

   a. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the Federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
      1) The drug is approved by the FDA;
      2) The drug is prescribed for the treatment of a life-threatening condition, including cancer, HIV or AIDS;
      3) The drug has been recognized for treatment of that condition by one of the following: a) The American Medical Association Drug Evaluations; b) The American Hospital Formulary Service Drug Information; c) The United States Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
      4) When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements of this benefit.

b. 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.

9. **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.

10. **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.

11. **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. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

    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.

12. **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.

13. **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.

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

8. **Student Health Center/Infirmary Expense Benefit i**f an Insured Student incurs expenses as the result of treatment at a Student Health Center/Infirmary, we will pay the expenses incurred. Benefits will not exceed the amount shown in the Schedule of Benefits.

9. **Sports Accident Expense Benefit** for an Insured Student as the result of covered sports accident while at play or practice of intercollegiate sports as shown in the Schedule of Benefits.

10. **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.

   f. 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.

   g. 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).

11. **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

Mandated Benefits for Indiana

Dental Anesthesia Benefit for expenses incurred for dental care for an Insured Person with a Disability if the mental or physical condition of such Insured Person requires dental treatment to be rendered in a Hospital or an ambulatory outpatient surgical center.

As used in this Benefit:
Insured Person with a Disability means an individual who has a physical or mental impairment that substantially limits one or more of the major life activities of the individual and any person who has a record of or is regarded as having such impairment.

Mastectomy, Reconstructive Surgery and Prosthetic Devices will be covered under the Inpatient Surgery Benefit on the same basis as any other surgical procedure. We will provide hospitalization benefits for at least 48 hours following a mastectomy. In the case of an early release, coverage for a mastectomy will include at least one home care visit if ordered by the attending Physician. We will also pay the Usual and Reasonable expenses incurred for prosthetic devices and/or reconstructive surgery of the breast on which surgery for breast cancer has been performed and surgery of the non-diseased breast, if determined as necessary by the Insured Person's attending Physician.

As used in this benefit:
Prosthetic Device means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the Insured Person's Physician and surgeon.

Diabetes Equipment, Supplies and Service for expenses incurred for Medically Necessary treatment for diabetes, including Medically Necessary supplies and equipment as ordered in writing by Physician or podiatrist. Equipment and supplies that may be necessary for the treatment of diabetes include, but are not limited to the following. We will pay the Usual and Reasonable charges incurred for such supplies:

1. Lancets and automatic lancing devices
2. Glucose test strips
3. Blood glucose monitors
4. Blood glucose monitors for visually impaired
5. Control solutions used in blood glucose monitors
6. Diabetes data management systems for management of blood glucose
7. Urine testing products for glucose and ketones
8. Oral anti-diabetic agents used to reduce blood sugar levels
9. Alcohol swabs
10. Syringes
11. Injection aids including insulin drawing up devices for the visually impaired
12. Cartridges for the visually impaired
13. Disposable insulin cartridges and pen cartridges
14. All insulin preparations
15. Insulin pumps and equipment for the use of the a pump including batteries
16. Insulin infusion devices
17. Oral agents for treating hypoglycemia such as glucose tablets and gels
18. Glucagon for injection to increase blood glucose concentration
19. Other diabetes equipment and related supplies necessary for the treatment of diabetes

Diabetes Self-Management for expenses incurred for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and Treatment of their diabetic condition, including information on proper diets. This benefit will be limited to visits necessary upon the diagnosis of diabetes, where a Physician diagnoses a significant change in the Insured Student's symptoms or conditions that necessitate changes in an Insured Student's self-management or where reeducation or refresher education is necessary.

Such education must be provided by a health care profession who is licensed, registered, or certified under IC 15 and has specialized training in the management of diabetes.

Inherited Metabolic Disease for medical food that is medically necessary and prescribed by the Insured Person's Physician for treatment of Inherited Metabolic Disease.

As used in this benefit:
Inherited Metabolic Disease means a disease caused by inborn errors of amino acid, organic acid, or urea cycle metabolism and is treatable by dietary restriction of one or more amino acids.

Medical Food means a formula that is intended for dietary treatment for which nutritional requirements are established by a medical evaluation. Such food must be formulated to be consumed enterally, under direction of a Physician.

Prostate Cancer Screening for expenses incurred during testing for prostate cancer on the same basis as any other Covered Sickness. Coverage is provided for at least one prostate-specific antigen test annually for an Insured person who is age 50 or older or at least one prostate-specific antigen test annually for an Insured Person under age 50 who is at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society.

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.

SECTION VI - EXCLUSIONS AND LIMITATIONS

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

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

- **International Students Only -**expenses incurred within the Insured Person's Home Country or country of regular domicile, that exceeds the benefit amount shown in the Schedule of Benefits.
- medical services rendered by provider employed for or contracted with the School, including team physicians or trainers, except as specifically provided in the Schedule of Benefits.
- dental treatment including orthodontic braces and orthodontic appliances, except as specified for accidental Injury to the Insured Person's Sound, Natural Teeth.
- birth control, including elective surgical procedures or devices, except as specifically provided in the Schedule of Benefits.
- expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- loss incurred as the result of riding as a passenger or otherwise (including skydiving) in a vehicle or device for aerial navigation, except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route anywhere in the world.
- 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 in excess of $600.00 per Accident.
- loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- intentionally self-inflicted Injury, attempted suicide, or suicide, while sane or insane.

- expenses payable under any prior Policy which was in force for the person making the claim.
- Injury sustained as the result of the Insured Person's operation of a motor vehicle while not properly licensed to do so in the jurisdiction in which the motor vehicle accident takes place.
- expenses incurred after:
  - The date insurance terminates as to the Insured Person; and
  - The end of the Benefit Period specified in the Benefit Schedule.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the policy.
- charges incurred for chiropractic care, acupuncture, physical therapy, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
- expenses for services or supplies in connection with eye examination including radial keratotomy, eye glasses or contact lenses, or hearing aids except those resulting from a Covered Injury or as provided in the Pediatric Vision Care benefit;
- 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).

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

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

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

COORDINATION OF THIS POLICY'S BENEFITS WITH OTHER BENEFITS

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

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

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

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

3. The order of benefit determination rules determine whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one Plan.

   When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

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

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

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

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

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by two or more Plans, the rules for determining the order of benefit payments are as follows:

A. The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of under any other Plan.

B. (1) Except as provided in Paragraph (2), a Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the Policy holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:
   (1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan . However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent, and primary to the Plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.
   (2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:
      (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
         i. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or
         ii. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

      However, if one spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.
      (b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) above shall determine the order of benefits;
         iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) above shall determine the order of benefits; or
         iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            • The Plan covering the Custodial parent;
            • The Plan covering the spouse of the Custodial parent;
            • The Plan covering the non-custodial parent; and then
            • The Plan covering the spouse of the non-custodial parent.

(c) For a dependent child covered under more than one Plan of individuals who are not the parents of the child, the provisions of Subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D(1) can determine the order of benefits.

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

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

EFFECT ON THE BENEFITS OF THIS PLAN

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

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

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

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

FACILITY OF PAYMENT

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

RIGHT OF RECOVERY

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

SECTION VII - GENERAL POLICY PROVISIONS

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

Notice of Claim: Written notice of a claim must be given to Us within 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: We shall pay or deny each clean claim as follows:
1. If the claim is filed electronically, within thirty (30) days after the date the claim is received by Us; and
2. If the claim is filed on paper, within forty-five (45) days after the date the claim is received by Us.

If We fail to pay or deny a clean claim in the time required above and We subsequently pay the claim, We shall pay interest equal to the percentage rounded to the nearest whole number that equals the average investment yield on state money for the state's previous fiscal year, excluding pension fund investments, as published in the auditor of state's comprehensive financial report per month until the claim is adjudicated. If We fail to pay benefits when due, the Insured Person entitled to such benefits may bring action to recover such benefits and any damages.

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

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

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

Physical Examination and Autopsy: We, at Our own expense, will have the right and opportunity to examine the person of an individual whose Injury or Sickness is the basis of a claim when and as often as it may reasonably require during the pendency of a claim hereunder. In the case of death of an Insured Person, We may have an autopsy performed unless prohibited by law.

Legal Actions: No action at law or in equity will be brought to recover on this Policy prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Policy. No such action will be brought after the expiration of three years after the time written proof of loss is required to be furnished.

Conformity with State Statutes: Any provision of this Policy which, on its Effective Date, is in conflict with the statutes of the state in which this Policy was delivered or issued for delivery is hereby amended to conform to the minimum requirements of such statutes.

SECTION VIII - ADDITIONAL PROVISIONS

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

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

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

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

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

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

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

8. Benefits are payable under this Policy only for those expenses incurred while the Policy is in effect as to the Insured Person. No benefits are payable for expenses incurred after the date the insurance terminates for the Insured Person, except as may be provided under Extension of Benefits.

SECTION IX – APPEALS PROCEDURE

If an Insured Person has a grievance or is appealing a grievance decision, contact us either orally or in writing:

The Claims Administrator:
National Guardian Life Insurance Company
Student Insurance Division
Appeal Department
Commercial Travelers Building
70 Genesee Street
Utica, NY 13502
1-800-756-3702

Notice to Insured
Upon the Insured Person's notice of a grievance, we or our agent shall provide timely, adequate, and appropriate notice to each insured of:
1. the grievance procedure required under Indiana law;
2. the external grievance procedure required under Indiana law;
3. information on how to file a grievance and a request for an external grievance review permitted under Indiana law; and
4. a toll free telephone number through which an Insured Person may contact Us at no cost to the Insured Person to obtain information and to file grievances.

Resolution of Grievances:
We will:
1. Acknowledge the receipt of a grievance given orally or in writing to the Insured Person within five (5) business days after receipt of the grievance;
2. Document the substance of the grievance and any actions taken;
3. Investigate the substance of the grievance, including any aspects involving clinical care;
4. Notify the covered individual of the disposition of the grievance and the right to appeal; and
5. Appoint at least one (1) individual to resolve a grievance.
6. Provide the Insured Person filing a grievance the following standard time lines:
    a. A grievance will be resolved as expeditiously as possible, but not more than twenty (20) business days after we receive all information reasonably necessary to complete the review. If We are unable to make a decision regarding the grievance within the twenty (20) day period due to circumstances beyond Our control, We shall:
        1) before the twentieth business day, notify the Insured Person in writing of the reason for the delay; and
        2) issue a written decision regarding the grievance within an additional ten (10) business days.
    b. We shall notify an Insured Person in writing of the resolution of a grievance within five (5) business days after completing an investigation. The grievance resolution notice will include the following:
        1) a statement of Our decision;
        2) a statement of the reasons, policies, and procedures that are the basis of the decision;
        3) notice of the Insured Person's right to appeal the decision; and
        4) the department, address and telephone number through which an Insured Person may contact a qualified representative to obtain additional information about the decision or the right to appeal.
    c. For an external grievance, the independent review organization will:
        1) Within seventy-two (72) hours after the expedited external grievance is filed; or
        2) Within fifteen (15) business days after a standard external grievance is filed;

        Make a determination to uphold or reverse Our appeal resolution based on information gathered from the Insured Person or the Insured Person's designee, Us, the treating health care provider, and any other information that the independent review organization considers necessary and appropriate. The independent review organization will notify the Insured Person, the Insured Person's designee, and Us of the determination within:
        1) seventy-two (72) hours after the grievance is filed for an expedited external grievance; or
        2) seventy-two (72) hours after making the determination for a standard external grievance.

Resolution of Appeals of Grievance Decisions:
We will:
1. Acknowledge the receipt of an appeal of a grievance decision given orally or in writing to the Insured Person within five (5) business days after the appeal is filed;
2. Document the substance of the appeal and any actions taken by the Policyholder Service and Claims Committee;
3. Investigate the substance of the appeal, including any aspects involving clinical care;
4. Notify the covered individual of the disposition of the appeal and that the Insured Person may have the right to further remedies allowed by law;
5. Provide the Insured Person filing an appeal of a grievance decision the following standard time lines:
    a. An appeal of a grievance decision will be resolved as expeditiously as possible, but not more than forty-five (45) days after the appeal is filed.

b. We shall notify an Insured Person in writing of the resolution of an appeal of a grievance decision within five (5) business days after completing an investigation. The appeal resolution notice will include the following:
   1) a statement of Our decision;
   2) a statement of the reasons, policies, and procedures that are the basis of the decision;
   3) notice of the Insured Person's right to further remedies allowed by law, including the right to external grievance review by an independent review organization; and
   4) the department, address and telephone number through which an Insured Person may contact a qualified representative to obtain additional information about the decision or the right to an external grievance review.

External Grievance Procedural Requirements:

1. An external grievance procedure established under Indiana law must allow the Insured Person or an Insured Person's representative to file a written request with Us for an external grievance review of Our appeal resolution not more than one hundred twenty (120) days after the Insured Person is notified of the resolution.
2. An Insured Person may not file more than one (1) external grievance of Our appeal resolution.
3. The independent review organization and the medical review professional conducting the external review may not have a material professional, familial, financial, or other affiliation with any of the following:
   a. Us, the insurer;
   b. any of Our officer, director, or management employees;
   c. The health care provider or the provider's medical group that is proposing the service;
   d. The facility at which the service would be provided;
   e. The development of manufacture of the principal drug, device, procedure, or the therapy that is proposed for use by the health care provider; or
   f. The Insured Person requesting the external grievance review.
4. The Insured Person who files an external grievance shall:
   a. not be subject to retaliation for exercising the right to file an external grievance;
   b. be permitted to utilize the assistance of other individuals, including health care providers, attorneys, friends, and family members throughout the review process;
   c. cooperate with the independent review organization by:
      1) providing any requested medical information; or
      2) authorizing the release of necessary medical information
5. The Insured Person shall not pay any of the costs associated with the services of an independent review organization. All costs must be paid by Us.
6. The determination by the review organization shall:
   a. Within fifteen (15) business days after the appeal is filed make a determination to uphold or reverse Our appeal resolution based on information gathered from the Insured Person or Insured Person's representative, the treating health care provider, and any additional information that the independent review organization considers necessary and appropriate.
   b. apply standards of decision making that are based on objective clinical evidence and the terms of this Policy;
7. The review organization shall:
   a. notify Us and the Insured Person of the determination made within seventy-two (72) hours after making the determination;
   b. upon the request of the Insured Person, provide to the Insured Person all information reasonably necessary to enable the covered individual to understand the:
      1) effect of the determination on the Insured Person; and
      2) the manner in which We may be expected to respond to the determination.

Submission of New Information

1. If, at any time during an external review performed under this Policy, the Insured Person submits information to Us that is relevant to Our resolution of the Insured Person's Appeal of a Grievance Decision and that was not considered by Us under the Internal Grievance Procedures:
   a. We may reconsider the resolution; and
   b. if We choose to reconsider, the Independent Review Organization shall cease the external review process until the reconsideration is complete.

2. We shall reconsider the resolution of an Appeal of a Grievance Decision due to the submission of new information and notify the Insured Person of Our decision within fifteen (15) days after the information is submitted.
3. If the decision reached under is adverse to the Insured Person, the Insured person may request that the Independent Review Organization resume the external review under the policy.
4. If based on the new information submitted to us We choose not to reconsider Our resolution we shall forward the new information to the Independent review Organization not more than two (2) business days after We receive it.

Grievance means any dissatisfaction expressed by or on behalf of an Insured Person regarding:

1. a determination that a service or proposed service is not appropriate or medically necessary;
2. a determination that a service or proposed service is experimental or investigational;
3. the availability of participating providers;
4. the handling or payment of claims for health care services; or
5. matters pertaining to the contractual relationship between:
   a. an Insured Person and an insurer; or
   b. a group policyholder and an insurer

   and for which the Insured Person has a reasonable expectation that action will be taken to resolve or reconsider the matter that is the subject of dissatisfaction.

NOTICE

Questions regarding your policy or coverage should be directed to:

National Guardian Life Insurance Company
c/o Administrator: National Guardian Life Insurance Company
Student Insurance Division
Commercial Travelers Building
70 Genesee Street
Utica, NY 13502
1-800-756-3702

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, Indiana 46204
Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at www.in.gov/idoi.

National Guardian® Life Insurance Company
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PRESCRIPTION DRUG RIDER

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

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

Prescription Drugs Retail Pharmacy Cost sharing does not apply to Affordable Care Act (ACA) Preventive Care prescriptions are filled at a participating network pharmacy.	
DESCRIPTION	**COST SHARING DESCRIPTION**
Retail	
Generic	The Usual and Reasonable Charge stated in the Schedule of Benefits Copayment: $5.00
Preferred Brand Drug	The Usual and Reasonable Charge stated in the Schedule of Benefits Copayment: $25.00
Brand-Name Drug	The Usual and Reasonable Charge stated in the Schedule of Benefits Copayment: $50.00

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

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

Formulary means a list of medications covered by the Policy. Use of medications listed the Formulary is intended to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary lists the type of drug and tier status.

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

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

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

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

8. Prescription Drugs

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

1. **Off-Label Drug Treatments** benefits are available if all of the conditions listed below are met. It is the responsibility of the prescribing Physician to submit documentation to Us that supports compliance with these conditions.
   a. The drug is approved by the FDA;
   b. The drug is prescribed for the Treatment of a Life-Threatening condition, including cancer, HIV or AIDS;
   c. The drug has been recognized for Treatment of that condition by one of the following: a) The American Medical Association Drug Evaluations; b) The American Hospital Formulary Service Drug Information; c) The United States Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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

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

3. **Tobacco cessation prescription and over-the-counter (OTC) drugs** benefits are payable for tobacco cessation prescription drugs and OTC drugs will be covered for two 90-day treatment regimens only. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.studentplanscenter.com or call 1-800-756-3702.

LIMITATIONS AND EXCLUSIONS

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

LIMITATIONS

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

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

   As used in this benefit, Specialty Prescription Drugs are Prescription Drugs which:
   a. Are only approved to treat limited patient populations, indications, or conditions;
   b. Are normally injected, infused, or require close monitoring by a Physician or clinically trained individual; or
   c. Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

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

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

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

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

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

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

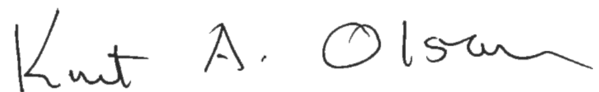
EXCLUSIONS

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

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

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

NATIONAL GUARDIAN LIFE INSURANCE COMPANY



President

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.

IMPORTANT NOTICE

COMMERCIAL TRAVELERS' POLICYHOLDER SERVICE OFFICE is here to serve you . . .

Your satisfaction is very important to us. Should you have a valid claim, we fully expect to provide a fair settlement in a timely fashion.

If you are not satisfied, please let us know. You may write to us or call our Toll-free number for a prompt review of your claim at:

National Guardian Life Insurance Company
Student Insurance Division
Commercial Travelers Building
70 Genesee Street
Utica, New York 13502
TELEPHONE: 1-800-756-3702

We will do the best we can to provide a fair settlement or offer you a clear explanation of why your claim was not paid as you requested. If you are still not satisfied, or feel you are not being treated fairly, we want you to know you may contact the INDIANA DEPARTMENT OF INSURANCE with your complaint and seek assistance from the governmental agency that regulates insurance.

To contact the Department, write or call:

INDIANA DEPARTMENT OF INSURANCE
Public Information/Market Conduct
311 West Washington Street, Suite 300
Indianapolis, IN 46204-2787

Consumer Hotline: 1-800-622-4461 – In the Indianapolis Area: 1-317-232-2395

INDIANA LIFE AND HEALTH INSURANCE GUARANY ASSOCIATION

SUMMARY DOCUMENT

The Indiana Life and Health Insurance Guaranty Association provides coverage of claims under some types of policies if the insurer becomes impaired or insolvent. COVERAGE MAY NOT BE AVAILABLE FOR YOUR POLICY. Even if coverage is provided, there are significant limits and exclusions. Coverage is always conditioned on the residence in this state. Other conditions may also preclude coverage.

The Indiana Life and Health Insurance Guaranty Association will respond to any questions you may have which are not answered by this document. Your insurer and agent are prohibited by law from using the existence of the association or its coverage to sell you an insurance policy.

You should not rely on availability of coverage under the Indiana Life and Health Insurance Guaranty Association when selecting an insurer.

You may contact the Indiana Life and Health Insurance Guaranty Association as follows:

Indiana Life and Health Insurance Guaranty Association
251 E. Ohio Street, Suite 1070
Indianapolis, IN 46204
(317) 636-8204
www.inlifega.org

You may contact the Indiana Department of Insurance as follows:

Indiana Department of Insurance
311 W. Washington Street
Indianapolis, IN 46204
(317) 232-2385
www.in.gov/idoi

NOTICE OF PROTECTION PROVIDED BY THE INDIANA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a brief summary of the Indiana Life and Health Insurance Guaranty Association ("ILHIGA") and the protection it provides for policy holders. ILHIGA was established to provide protection to policy holders in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations. If this should happen, ILHIGA will typically arrange to continue coverage and pay claims, in accordance with Indiana law, with funding from assessments paid by other insurance companies.

Basic Protections Currently Provided by ILHIGA

Generally, an individual is covered by ILHIGA if the insurer was a member of ILHIGA and the individual lives in Indiana at the time the insurer is ordered into liquidation with a finding of insolvency. The coverage limits below apply only for companies placed in rehabilitation or liquidation on or after January 1, 2013.

Life Insurance

- $300,000 in death benefits
- $100,000 in cash surrender or withdrawal values

Health Insurance

- $500,000 in basic hospital, medical and surgical or major medical insurance benefits
- $300,000 in disability and long term care insurance
- $100,000 in other types of health insurance

Annuities

- $250,000 in present value of annuity benefits (including cash surrender or withdrawal values)
- $5,000,000 for covered unallocated annuities

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to basic hospital, medical and surgical or major medical insurance benefits.

The protections listed above apply only to the extent that benefits are payable under covered policy(s). In no event will the ILHIGA provide benefits greater than those given in the life, annuity or health insurance policy or contract. The statutory limits on ILHIGA coverage have changed over the years and coverage in prior years may not be the same as that set forth in this notice.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) 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 variable annuity contract.

To learn more about the protections provided by ILHIGA, please visit the ILHIGA website at www.inlifega.org or contact:

Indiana Life & Health Insurance
Guaranty Association
3502 Woodview Trace Suite 100
Indianapolis, IN 46268
317-636-8204

Indiana Department of Insurance
311 West Washington Street, Suite 103
Indianapolis, IN 46204
317-232-2385

The policy or contract that this notice accompanies might not be fully covered by ILHIGA and even if coverage is currently provided, coverage is (a) subject to substantial limitations and exclusions (some of which are described above), (b) generally conditioned on continued residence in Indiana, and (c) subject to possible change as a result of future amendments to Indiana law and court decisions.

Complaints to allege a violation of any provision of the Indiana Life and Health Guaranty Association Act must be filed with the Indiana Department of Insurance, 311 W. Washington Street, Suite 103, Indianapolis, IN 46204; (telephone) 317-232-2385.

Insurance companies and agents are not allowed by Indiana law to use the existence of ILHIGA or its coverage to encourage you to purchase any form of insurance (IC 27-8-8-18(a)). When selecting an insurance company, you should not rely on ILHIGA coverage. If there is any inconsistency between this notice and Indiana law, Indiana law will control.

Questions regarding the financial condition of a company or your life, health insurance policy or annuity should be directed to your insurance company or agent.

National Guardian Life Insurance Company
Commercial Travelers Life Insurance Company

JOINT NOTICE OF PRIVACY PRACTICES

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

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

How We May Use or Disclose Your Health Information

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

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

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

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

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

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

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

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

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

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

When We May Not Use or Disclose Your Health Information

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

Statement of Your Health Information Rights

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

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

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

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

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

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

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

Our Obligations Under This Notice

We are required by law to:

1. Maintain the privacy of your health information.

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

3. Abide by the terms of this Notice.

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

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

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

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

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

Complaints

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

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

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

Effective Date of This Notice: June 12, 2017

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

APPLICATION FOR STUDENT BLANKET ACCIDENT AND SICKNESS INSURANCE

1. Name of School, College or University: ______________________________

   Address: ______________________________

2. Plan of Benefits:

   ❑ Same as current year's program, except ______________________________

   ❑ In accordance with proposal dated ______________ , 20 ______________

   ❑ Other ______________________________

3. Premium Rates: Student: __________ Annually

4. Terms of coverage, from ______________ To ______________

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	Position or Title	Date

Agent/Broker Name ______________________________

Address ______________________________

____

Tax I.D./Social Security Number ______________________________