National Guardian Life Insurance Company
It's about people.

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

Administrator: Academic Health Plans, Inc.
P.O. Box 1605
Colleyville, TX 76034-1605
855-247-2273

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

This health plan satisfies Minimum Creditable Coverage standards and will satisfy the individual mandate that the individual have health insurance.

TABLE OF CONTENTS

INSURANCE INFORMATION SCHEDULE

POLICYHOLDER: Southern Methodist University
Dallas, Texas

POLICY NUMBER: 2019A4A24-01

EFFECTIVE DATE: August 1, 2019

TERMINATION DATE: August 1, 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	$2,776.00
Spouse Only	Annual	$2,776.00
Child(ren) Only	Annual	$2,776.00
Student Only	Fall	$1,388.00
Spouse Only	Fall	$1,388.00
Child(ren) Only	Fall	$1,388.00
Student Only	Spring/Summer	$1,388.00
Spouse Only	Spring/Summer	$1,388.00
Child(ren) Only	Spring/Summer	$1,388.00
Student Only	Summer	$ 698.00
Spouse Only	Summer	$ 698.00
Child(ren) Only	Summer	$ 698.00

CLASSES OF PERSONS	ENROLLMENT REQUIREMENTS	ENROLLMENT PERIOD	WAITING PERIOD
New Student	9 or more credit hours	31 Days	0 Days
Continuing Student	9 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 ☒ Waiver ☐ Mandatory ☐ Other (Specify)

INSURANCE INFORMATION SCHEDULE

POLICYHOLDER: Southern Methodist University
Dallas, Texas

POLICY NUMBER: 2019A4A24-02

EFFECTIVE DATE: September 9, 2019

TERMINATION DATE: September 9, 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	$2,776.00
Spouse Only	Annual	$2,776.00
Child(ren) Only	Annual	$2,776.00
Student Only	Fall	$ 902.00
Spouse Only	Fall	$ 902.00
Child(ren) Only	Fall	$ 902.00
Student Only	Spring	$ 902.00
Spouse Only	Spring	$ 902.00
Child(ren) Only	Spring	$ 902.00
Student Only	Summer	$ 594.00
Spouse Only	Summer	$ 594.00
Child(ren) Only	Summer	$ 594.00

CLASSES OF PERSONS	ENROLLMENT REQUIREMENTS	ENROLLMENT PERIOD	WAITING PERIOD
New Student	9 or more credit hours	31 Days	0 Days
Continuing Student	9 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 ☒ Waiver ☐ Mandatory ☐ Other (Specify)

SCHEDULE OF BENEFITS
GOLD PLAN

Actuarial Value: 82.41% **Next Lower Metal Level: Silver**

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

Non-Network: The Deductible, Coinsurance, and any Copayment are not applicable to Preventive Services. Benefits are paid at 60% of the Usual and Reasonable charge.

Deductible:

Network	Individual	$400.00
	Family	$1,200.00
Non-Network	Individual	$1,200.00
	Family	$3,600.00

Out-of-Pocket Expense Limit:

Network	Individual	$7,900.00
	Family	$12,700.00
Non-Network	Individual	$10,000.00
	Family	$37,500.00

Coinsurance Amount:

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

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

Preferred Provider Organization:
To locate a Cigna Provider in Your area, consult Your Provider Directory. You may call toll-free 1-855-357-0242 or visit our website at smu.myahpcare.com.

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; AND**
3. **DETERMINED BY WHETHER THE SERVICE OR TREATMENT IS PROVIDED BY A NETWORK OR NON-NETWORK PROVIDER.**

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE NETWORK PROVIDER	BENEFIT AMOUNT PAYABLE NON-NETWORK PROVIDER
Inpatient Benefits		
Hospital Room & Board Expenses	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospital Intensive Care Unit Expense ***- in lieu of normal Hospital Room & Board Expenses***	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE NETWORK PROVIDER	BENEFIT AMOUNT PAYABLE NON-NETWORK PROVIDER
Inpatient Benefits *(continued)*		
Hospital Miscellaneous Expenses for services & supplies, such as cost of operating room, lab tests, prescribed medicines, X-ray exams, therapeutic services, casts & temporary surgical appliances, oxygen, blood & plasma, misc. supplies	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Preadmission Testing	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Physician's Visits while Confined	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Surgery:		
Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Physical Therapy (inpatient)	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Skilled Nursing Facility Expense Benefit 25 days per Policy Year	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Mental Health Disorder Benefit	Same as any other Covered Sickness	
Substance Use Disorder Benefit	Same as any other Covered Sickness	
Outpatient Benefits		
Outpatient Surgery:		
Surgeon Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Anesthetist	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Assistant Surgeon	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Outpatient Surgery Miscellaneous (excluding not-scheduled surgery) – expenses for services & supplies, such as cost of operating room, therapeutic services, oxygen, oxygen tent, and blood & plasma	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE NETWORK PROVIDER	BENEFIT AMOUNT PAYABLE NON-NETWORK PROVIDER
Outpatient Benefits *(continued)*		
Rehabilitation Therapy including cardiac rehabilitation, pulmonary rehabilitation, physical therapy, occupational therapy and speech therapy 35 visits per Policy Year Habilitative Services are covered to the extent that they are Medically Necessary	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Emergency Services Expenses	80% of PPO Allowance for Covered Medical Expenses Copayment: $250.00 Deductible Waived Copayment waived if admitted	80% of PPO Allowance for Covered Medical Expenses Copayment: $250.00 Deductible Waived Copayment waived if admitted
In Office Physician's Visits	100% of PPO Allowance for Covered Medical Expenses Copayment: $30.00 Deductible Waived	60% of Usual and Reasonable Charge for Covered Medical Expenses
Urgent Care Centers or Facilities	100% of PPO Allowance for Covered Medical Expenses Copayment: $50.00 Deductible Waived	60% of Usual and Reasonable Charge for Covered Medical Expenses
Diagnostic X-ray Services	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Laboratory Procedures (Outpatient)	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Prescription Drugs All prescriptions are limited to a 30-day retail supply including diabetic supplies	100% of PPO Allowance for Covered Medical Expenses Generic Copayment: $25.00 Preferred Brand Copayment: $50.00 Brand Copayment: $75.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Subject to $25.00 Generic Copayment Subject to $50.00 Preferred Brand Copayment Subject $75.00 Brand Copayment
Outpatient Miscellaneous Expense for services not otherwise covered but excluding surgery	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Home Health Care Expenses up to 60 visits per Policy Year	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hospice Care Coverage	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Routine Adult Eye Exam (Adults) Limited to one eye exam per Policy Year.	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
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 NETWORK PROVIDER	BENEFIT AMOUNT PAYABLE NON-NETWORK PROVIDER
Other Benefits		
Ambulance Service	80% of PPO Allowance for Covered Medical Expenses	80% of Usual and Reasonable Charge for Covered Medical Expenses
Durable Medical Equipment	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Hearing Aid or Cochlear Implant Expense Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
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	100% of PPO Allowance for Covered Medical Expenses Copayment: $50.00 Deductible Waived	60% of Usual and Reasonable Charge for Covered Medical Expenses
Accidental Injury Dental Treatment for Insured Person's over age 18	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Student Health Center/Infirmary Expense	80% of Usual and Reasonable Charge for Covered Medical Expenses Deductible Waived	
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:*	See Benefit for limitations 100% of PPO Allowance for Preventive Services	See Benefit for limitations The Coinsurance Amount for Preventive Dental Care is 80% of Usual and Reasonable
Emergency Dental	50% Usual and Reasonable	50% Usual and Reasonable
Clinical Oral Evaluations	50% Usual and Reasonable	50% Usual and Reasonable
Endodontic Services	50% Usual and Reasonable	50% Usual and Reasonable
Periodontal Services	50% Usual and Reasonable	50% Usual and Reasonable
Prosthodontic Services	50% Usual and Reasonable	50% Usual and Reasonable
Medically Necessary Orthodontic Care	50% Usual and Reasonable	50% Usual and Reasonable
Pediatric Vision Care Benefit limited to 1 visit(s) and 1 pair of prescribed lenses and frames per Policy Year	See Benefit for Limitations 100% of PPO Allowance for Preventive Services	60% Usual and Reasonable
MANDATED BENEFITS		
Tempormandibular Benefit On the same basis as diagnostic of surgical treatment of conditions affecting other skeletal joints	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Amino Acid-based Elemental Formulas Benefit	Same as any other outpatient Prescription Drug	
Acquired Brain Injury Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Early Detection of Cardiovascular Diseases Subject to $200 benefit limit every *five* years	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

BENEFITS FOR COVERED INJURY/SICKNESS	BENEFIT AMOUNT PAYABLE NETWORK PROVIDER	BENEFIT AMOUNT PAYABLE NON-NETWORK PROVIDER
MANDATED BENEFITS *(continued)*		
Clinical Trials Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Reconstructive Surgery for Craniofacial Abnormalities Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Dental Anesthesia Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Diabetes Expense Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Phenylketonuria Treatment Benefit	Same as any other outpatient Prescription Drug	
Prosthetic and Orthotic Devices Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Telehealth Services and Telemedicine Service Benefit:	100% of PPO Allowance for Covered Medical Expenses	100% of Usual and Reasonable Charge for Covered Medical Expenses
Inpatient Mastectomy and Reconstructive Surgery Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Child Immunizations Benefit	Same as any other Preventive Service	
Hearing Test Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses
Must Offer Benefits		
Loss or Impairment of Speech and Hearing Benefit	80% of PPO Allowance for Covered Medical Expenses	60% of Usual and Reasonable Charge for Covered Medical Expenses

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.

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.

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.

Notice of Creditable Coverage: Coverage under this student health plan is "creditable coverage." An Insured Person may need a certificate of Creditable Coverage if he or she becomes covered under a group health plan or other health plan within 63 days after their coverage under this health plan terminates. Upon termination of an Insured Person's coverage under this plan, the Insured Person will be issued a Certificate of Creditable Coverage. An Insured Person may request a Certificate of Creditable Coverage within 24 months of termination of coverage under this plan.

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 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, placed for adoption irrespective of whether the adoption has become final, or any Child for whom the Insured Student or Insured Student's covered Spouse is a party in a suit for adoption of such Child. Coverage is in effect from the date of adoption, the date of Placement for Adoption, or the date the Insured Student or Insured Student's covered Spouse is a party in a suit for adoption.

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.

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.

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

1. If an Insured Person is Hospital confined for Covered Injury or Covered Sickness on the date his or her insurance terminates, we will continue to pay benefits for 90 days from the Termination Date while such confinement continues.

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

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

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

SECTION IV – DEFINITIONS

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

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

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

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

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

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

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

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

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

Copayment means the amount of Usual and Reasonable expenses for treatment that We do not pay. The Insured Person is responsible for paying this portion of the expenses incurred. Any Copayment amounts are shown in the Schedule of Benefits.

Country of Assignment means the country in which an Eligible International Student, scholar or visiting faculty member is:

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

Covered Injury means a bodily injury that is:

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

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

1. From the date of Injury; and
2. Until the date services or supplies are received,

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

Covered Medical Expense means those charges for any 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.

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 child, adopted child or child pending adoption, child under a medical support order under an order issued under Chapter 154, Family Code, or enforceable by a court in this state, stepchild under age 26; and
3. An Insured Student's grandchild who unmarried, under age 25 and dependent on the Insured Student for federal income tax purposes at the time application for coverage of the grandchild is made; and
4. An Insured Student's covered dependent child 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 (unless otherwise covered under the Invitro Fertilization Benefit), learning disabilities (unless otherwise covered under the Developmental Delays in Children Benefit), routine physical examinations, fertility tests and pre-marital examinations, preventive medicines or vaccines except when required for the treatment of Covered Injury or Covered Sickness to the extent coverage is not required by state or federal law. **Elective Surgery** includes, but is not limited to, circumcision, tubal ligation, vasectomy, breast reduction, sexual reassignment surgery, submucous resection and/or other surgical correction for a deviated nasal septum, other than for necessary treatment of acute sinusitis to the extent coverage is not required by state or federal law. Elective surgery does not include Plastic or Cosmetic Surgery required to correct an abnormality caused by a Covered Injury or Covered Sickness.

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

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

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

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

Formulary means a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost-effective medications. The Formulary includes Generic, Brand, and Preferred Brand Drugs.

Generic Drugs means a drug that is identical or bioequivalent to a Brand Named drug in dosage form, safety, strength, route of administration, quality, performance characteristics, intended use and is not protected by a patent.

Heritable Disease means an inherited disease that may result in mental or physical retardation or death.

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

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

Hospital does not include the following:
1. Convalescent homes or convalescent, rest or nursing facilities;
2. Facilities primarily affording custodial, educational, or rehabilitory care; or
3. Facilities for the aged, drug addicts or alcoholics.

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

Immediate Family Member means the Insured Person and his or her spouse or the parent, child, brother or sister of the Insured Person or his or her spouse.

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.

Network Providers are Physicians, Hospitals and other healthcare providers who have contracted with Us to provide specific medical care at negotiated prices.

Nervous, Mental or Emotional Disorder means any neurosis, psychoneurosis, psychopathy, psychosis or mental or emotional disease of disorder of any kind.

Non-Network Providers have not agreed to any pre-arranged fee schedules.

Orthotic Device means a custom-fitted or custom-fabricated medical device that is applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease.

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

Phenylketonuria means an inherited condition that, if not treated, may cause severe mental retardation.

Physician means a:
1. Physician of Medicine (M.D.); or
2. Physician of Osteopathy (D.O.); or
3. Physician of Dentistry (D.M.D. or D.D.S.); or
4. Physician of Chiropractic (D.C.); or
5. Physician of Optometry (O.D.); or
6. Physician 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 Physician in the state where the service is rendered.

A Physician 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 Physician of Psychology must be prescribed by a Physician of Medicine.

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

The term Physician does not mean any person who is an Immediate Family Member.

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

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

Prosthetic Device means an artificial device designed to replace, wholly or partly, an arm or leg.

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

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

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

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

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.

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

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

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

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

SECTION V - DESCRIPTION OF BENEFITS

Benefit Payments

Preventive Services
The following services shall be covered without regard to any Deductible or Coinsurance requirement that would otherwise apply:
1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force.
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Insured Person involved.

3. With respect to Insured Persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
4. With respect to Insured Persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

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. The Maximum Benefit for all Covered Injury and Covered Sickness combined;
2. Any specified benefit maximum amounts;
3. Any Deductible amounts;
4. Any Coinsurance amount;
5. Any Copayments;
6. The Maximum Out-of-Pocket Expense Limit; and
7. Use of a Network Provider, if any.

The following are shown in the Schedule of Benefits:
- Deductible
- Maximum Benefit Amounts
- 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.

The total benefit payable for all Covered Medical Expenses resulting from Covered Injuries and Covered Sicknesses will never exceed the Maximum Benefit shown in the Schedule of Benefits. We will not pay for expenses incurred that do not meet the definition of Covered Medical Expense.

Preferred Provider Organization

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

If a Non-Network Provider is used, this Policy will pay the percentage of the Usual and Reasonable Covered Medical Expense shown in the Schedule of Benefits. The difference between the provider fee and the Coinsurance amount paid by Us will be the responsibility of the Insured Person.

Note, however, that We will pay at the PPO Allowance level for treatment by a Non-Network Provider if:
1. there is no Network Provider available to treat the Insured Person for a specific Covered Injury or Covered Sickness; or

2. there is an Emergency Medical Condition and the Insured Person cannot reasonably reach a Network Provider. This benefit will continue to be paid for the Emergency Medical Condition until the Insured Person can reasonably be expected to safely transfer to a Network Provider. If the transfer does not occur at that time, benefits will then be reduced and paid at the lower percentage applicable to a Non-Network Provider or
3. a Physician's or provider's participation in the Network is terminated, and at the time, an Insured Person whom the Physician or provider is currently treating has "Special Circumstances." "Special Circumstances" means a condition which a treating Physician or health care provider reasonably believes that discontinuing care by the treating physician or provider could cause harm to the Insured Person. Examples of an Insured Person who has a Special Circumstance include an Insured with a disability, acute condition, or life-threatening illness or an Insured who is past the 24th week of pregnancy.

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

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. Copayments and amounts above any Maximum Benefit do not apply toward the Out-of-Pocket Expense Limit. However, the Insured Person's Coinsurance amounts 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 Usual and Reasonable charges incurred for 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 -** We will pay the charges for routine tests performed as a preliminary to the Insured Person's being admitted to a Hospital. These tests must be performed within 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** - We will pay the expenses incurred for Physician's visits not to exceed one visit per day. Physician's visits will be paid for either inpatient or outpatient visits when incurred on the same day, but not both. Surgeon's fees are not payable under this benefit.

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

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

8. **Nervous, Mental or Emotional Disorders Treatment Expense -** We will pay the expenses incurred for the treatment of Nervous, Mental or Emotional Disorders while Confined as shown in the Schedule of Benefits.

9. **Skilled Nursing Facility Benefit** - We will pay for the expenses incurred for items and services provided as an inpatient in a skilled nursing bed of a Skilled Nursing Facility or Hospital, including room and board in semi-private accommodations. This coverage includes rehabilitative services; and drugs, biologicals, and supplies furnished for use in the skilled nursing facility and other medically necessary services and supplies. This coverage is limited to 25 days per Policy Year. Custodial or residential care in a skilled nursing facility or any other facility is not covered except as rendered as part of Hospice Care.

Outpatient Benefits

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

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.

3. **Outpatient Rehabilitation Therapy Services** - We will pay the Usual and Reasonable expenses for Rehabilitation Therapy services. Rehabilitation Therapy means services administered with the expectation that the therapy will result in practical improvement in the level of functioning within a reasonable period of time. This benefit includes Occupational Therapy, Physical Therapy, Speech Therapy and Manipulation Therapy. This coverage is limited to 35 visits per Policy Year for all therapy services combined.

   As used in this benefit:

   Occupational Therapy means treatment by means of constructive activities designed and adapted to promote the restoration of the person's ability to satisfactorily accomplish the ordinary tasks of daily living and those tasks required by the person's particular occupational role. Occupational Therapy does not include diversional, recreational, vocational therapies (e.g. hobbies, arts and crafts). We will not provide coverage for: supplies (looms, ceramic tiles, leather, utensils); therapy to improve or restore functions that could be expected to improve as the patient resumes normal activities again; general exercises to promote overall fitness and flexibility; therapy to improve motivation; suction therapy for newborns (feeding machines); soft tissue mobilization (visceral manipulation or visceral soft tissue manipulation), augmented soft tissue mobilization, myofascial; adaptions to the home such as rampways, door widening, automobile adaptors, kitchen adaptation and other types of similar equipment.

   Physical Therapy means treatment by physical means, hydrotherapy, heat, or similar modalities, physical agents, bio-mechanical and neuro-physiological principles and devices. Such therapy is given to relieve pain, restore function, and to prevent disability following illness, injury, or loss of a body part. We will not provide coverage for: maintenance therapy to delay or minimize muscular deterioration in patients suffering from a chronic disease or illness; repetitive exercise to improve movement, maintain strength and increase endurance (including assistance with walking for weak or unstable patients); range of motion and passive exercises that are not related to restoration of a specific loss of function, but are for maintaining a range of motion in paralyzed extremities; general exercise programs; diathermy, ultrasound and heat treatments for pulmonary conditions; diapulse; work hardening.

   Speech Therapy means therapy for the correction of a speech impairment.

   Manipulation Therapy includes Osteopathic/Chiropractic Manipulation Therapy used for treating problems associated with bones, joints and the back. The two therapies are similar, but chiropractic therapy focuses on the joints of the spine and the nervous system, while osteopathic therapy includes equal emphasis on the joints and surrounding muscles, tendons and ligaments.

   Manipulations whether performed and billed as the only procedure or manipulations performed in conjunction with an exam and billed as an office visit will be counted toward any maximum for Manipulation Therapy services as specified in the Schedule of Benefits. Manipulation Therapy services rendered in the home as part of Home Care Services are not covered.

4. **Emergency Services Expenses -** Only in connection with care for an Emergency Medical Condition as defined and incurred in a Hospital emergency room, urgent care center, 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 -** We will pay the expenses incurred 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 -** We will provide coverage for diagnostic X-ray services as shown in the Schedule of Benefits when prescribed by a physician.

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

8. **Prescription Drugs -**
   a. We will pay the expenses incurred for medication for which a Physician's written prescription is required up to the amount shown in the Schedule of Benefits. This benefit is limited to medication prescribed for the treatment of the Covered Injury or Covered Sickness for which a claim is made.
   b. Off-Label Drug Treatments - When prescription drugs are provided as a benefit of the issued Policy, they will include a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:
      i. The drug is approved by the FDA;
      ii. The drug is prescribed for the treatment of a chronic, disabling, or life-threatening illness;
      iii. The drug has been recognized for treatment of that condition by one of the following:
         (a) The American Medical Association Drug Evaluations;
         (b) The American Hospital Formulary Service Drug Information.
         (c) The United State Pharmacopoeia Dispensing Information, volume 1, "Drug Information for Health Care Professionals"; or
         (d) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is a clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

      When this portion of the prescription benefit is used, it will be the responsibility of the prescriber to submit to Us documentation supporting compliance with the requirements in items i., ii., and iii. of this benefit.
      As it pertains to this benefit, life threatening means either or both of the following:
         (a) Disease or conditions where the likelihood of death is high unless the course of the disease is interrupted; or
         (b) Disease or conditions with a potentially fatal outcome and where the end point of clinical intervention is survival.
   c. Contraceptives Benefit: This benefit includes prescription contraceptive drugs or devices approved by the United States Food and Drug Administration and an outpatient contraceptive service.
   d. Oral-Anticancer Medications: This benefit includes orally administered anticancer medication that is used to kill or slow the growth of cancerous cells.
   e. Specialty Drugs - "Specialty Drugs" are Prescription Drugs which:
      i. Are only approved to treat limited patient populations, indications, or conditions; or
      ii. Are normally injected, infused or require close monitoring by a Physician or clinically trained individual; or
      iii. Have limited availability, special dispensing and delivery requirements, and/or require additional patient support – any or all of which make the Drug difficult to obtain through traditional pharmacies.

9. **Nervous, Mental or Emotional Disorders Treatment -** We will pay the Usual and Reasonable expenses incurred for the Outpatient treatment of Nervous, Mental or Emotional Disorders as shown in the Schedule of Benefits. Such treatments must be performed by a licensed Physician or psychologist. Treatment may be performed in an office, Hospital or in a community mental health facility that is approved by the Joint Commission on Accreditation of Health Care Organizations, the Council on Accreditation for Children and Family Services or certified by the State Department of Mental Health.

   The treatments and services under the clinical supervision of a licensed Physician or psychologist must meet both of the following requirements:
   a. The services must be performed in accordance with a treatment plan that describes the expected duration, frequency and type of services performed; and
   b. The plan of treatments must be reviewed and approved by a licensed Physician or psychologist every three months.

10. **Outpatient Miscellaneous Expenses (Excluding surgery) -** We will pay the charges actually incurred for miscellaneous outpatient expenses (excluding surgery) incurred for the treatment and care of a Covered Injury or Covered Sickness. Expenses must be incurred on the advice of a Physician. Miscellaneous outpatient expenses include other reasonable expenses for services and supplies that have been prescribed by the attending Physician.

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

12. **Hospice Care Coverage -** When, as the result of a Covered Injury or Covered Sickness, an Insured Person requires Hospice Care, we will pay the expenses incurred for such care. The Insured Person must have been diagnosed with a terminal illness by a licensed Physician. Their medical prognosis must be death within six months. The Insured Person must have elected to receive palliative rather than curative care. Any required documentation will be no greater than that required for the same services under Medicare.

    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.

13. **Routine Eye Exam, Adult -** We cover one eye examination for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. This benefit is limited to one eye examination per Policy Year.

Other Benefits

1. **Ambulance Service -** We will pay the expenses incurred for transportation to or from a Hospital by ambulance.

2. **Substance Abuse Disorder Benefit -** We will pay the expenses incurred for the treatment of Substance Abuse on either an Inpatient or outpatient basis. Substance Abuse is as defined in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. This benefit is limited to a maximum of 3 series of treatment per the Insured Person's lifetime.

3. **Durable Medical Equipment -** We will pay the expense incurred 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. **Hearing Aid Benefit -** We will pay the Usual and Reasonable expenses incurred for one hearing aid per hearing-impaired ear up to one thousand dollars ($1,000) per hearing aid every 36 months. The coverage shall include all Medically Necessary hearing aids and services that are ordered by a Physician or an audiologist licensed in this State.

5. **Maternity Benefit** - We will pay the expenses incurred for maternity charges as follows:
    a. **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.

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

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

This benefit will apply to services provided in a medical setting or through home 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 "a", 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.

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

6. **Routine Newborn Care -** If expenses are incurred for routine newborn care during the first 31 days immediately following the birth of an Insured Person, We will pay the expenses incurred not to exceed the benefit specified in the Schedule of Benefits. Such expenses include, but are not limited to:
   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.

7. **Consultant Physician Services -** When requested and approved by the attending Physician.

8. **Pediatric Vision Care Benefit -** We will pay the Usual and Reasonable expenses incurred for one Visual Examination per Policy Year for Insured Students and Dependent Children up to age 19. This benefit includes refraction, vision training and orthoptic services. We will also pay the Usual and Reasonable expenses incurred for one pair of Prescribed Lenses and Frames per Policy Year for Insured Students and Dependent Children up to age 19.

   As used in this Benefit:

   Vision Examination means examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses.

   Prescribed Lenses & Frames means standard prescription lenses or contact lenses. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses.

9. **Pediatric Dental Exam Benefit -** We will pay the Usual and Reasonable expenses incurred for dental care and check-ups provided in the office of a dentist, including examinations, visits and consultations. The benefit is paid one time every six (6) months for Insured Students and Dependent Children up to age 19.

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

Mandated Benefits for Texas

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.

Tempormandibular Benefit: We will pay the Usual and Reasonable expenses incurred for Medically Necessary diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is as a result of an Accident, a trauma, a congenital defect, a developmental defect, or a pathology.

Amino Acid-based Elemental Formulas Benefit: We will pay the Usual and Reasonable expenses incurred for the treatment of an Insured Person who is diagnosed with;

1. immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
2. severe food protein-induced enterocolitis syndrome;
3. eosinophilic disorders, as evidenced by the results of a biopsy; and
4. impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

The treating Physician must have issued a written order stating that the amino acid-based elemental formula is Medically Necessary. Coverage of any Medically Necessary services associated with the administration of the formula is also provided. This benefit is covered on the same basis as other outpatient prescription drugs.

Acquired Brain Injury: We will pay the Usual and Reasonable expenses incurred for Medically Necessary treatment of an Acquired Brain Injury including:

1. Cognitive rehabilitation therapy which includes services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.
2. Cognitive communication therapy, which includes services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.
3. Neurocognitive therapy which includes services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.
4. Neurocognitive rehabilitation which includes services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.
5. neurofeedback therapy including services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.
6. Neurophysiological testing which is an evaluation of the functions of the nervous system.
7. Neurophysiological treatment which consists of interventions that focus on the functions of the nervous system.
8. Neuropsychological testing which is the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.
9. Neuropsychological treatment which consists of interventions designed to improve or minimize deficits in behavioral and cognitive processes.
10. Neurobehavioral treatment which consists of interventions that focus on behavior and the variables that control behavior.
11. Psychophysiological treatment which includes interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.
12. Remediation which is the process(es) of restoring or improving a specific function.
13. Post-acute care treatment services which are services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

14. Post-acute transition services which are services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.
15. Community reintegration services which are services that facilitate the continuum of care as an affected individual transitions into the community.

Early Detection of Cardiovascular Diseases*:* We will pay up to $200 of the Usual and Reasonable expenses incurred for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five (5) years as long as the Insured Person is covered under the Policy and the test is performed by a laboratory that is certified by a national organization recognized by the Texas Commissioner of Insurance:
1. Computed tomography (CT) scanning measuring coronary artery calcification; or
2. Ultrasonography measuring carotid intima-media thickness and plaque.

Coverage is limited to an Insured Person who is:
a. A male between 46 and 75 years of age; or
b. A female between 56 and 75; and
who is diabetic or has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

Clinical Trials Benefit: We will pay the Usual and Reasonable expenses incurred for routine patient care costs to an Insured Person in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:
1. the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
2. the National Institutes of Health;
3. the United States Food and Drug Administration;
4. the United States Department of Defense;
5. the United States Department of Veterans Affairs; or
6. an institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services

Routine patient care costs includes the costs of any Medically Necessary health care service for which benefits are provided under the Policy, without regard to whether the Insured Person is participating in a clinical trial. Routine patient care costs do not include:
1. the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2. the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3. the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. a cost associated with managing a clinical trial; or
5. the cost of a health care service that is specifically excluded from coverage under a health benefit plan.

Reconstructive Surgery for Craniofacial Abnormalities Benefit: We will pay the Usual and Reasonable expenses incurred for a Covered Dependent child who is younger than 18 years of age for reconstructive surgery for craniofacial abnormalities Medically Necessary to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

Dental Anesthesia Benefit: We will pay the Usual and Reasonable expenses incurred for an Insured Person who is unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the individual's Physician or by the dentist providing the dental care. Coverage is provided for facility charges and anesthesia only and on the same basis as any other Covered Sickness. Coverage is not provided for the procedure unless otherwise covered under the Policy.

Diabetes Expense Benefit: We will pay the Usual and Reasonable expenses incurred by an Insured Person who has been diagnosed with:

1. insulin dependent or noninsulin dependent diabetes; or
2. elevated blood glucose levels induced by pregnancy or another medical condition;

for diabetes equipment, supplies and self-management training programs and for immunizations for influenza and pneumococous.

Diabetes equipment and supplies include:

1. blood glucose monitors, including those designed to be used by or adapted for the legally blind and non-invasive glucose monitors;
2. test strips specified for use with a corresponding glucose monitor;
3. lancets and lancet devices;
4. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
5. insulin and insulin analog preparations;
6. injection aids, including devices used to assist with insulin injection and needleless systems;
7. insulin syringes;
8. biohazard disposal containers;
9. insulin pumps, both external and implantable, and associated appurtenances, which include insulin infusion devices, batteries, skin preparation items, adhesive supplies, infusion sets, insulin cartridges, durable and disposable devices to assist in the injection of insulin, and other required disposable supplies;
10. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
11. prescription medications and medications available without a prescription for controlling the blood sugar level;
12. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
13. glucagon emergency kits.

Diabetes self-management training must be provided by a health care practitioner or provider who is licensed, registered, or certified in Texas to provide appropriate health care services and who is acting within the scope of practice authorized by the practitioner's or provider's license, registration, or certification. Self-management training includes:

1. training provided to an Insured Person after the initial diagnosis of diabetes in the care and management of that condition, including nutrition counseling and proper use of diabetes equipment and supplies;
2. additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the Insured Person's symptoms or condition that requires changes in the self-management regime;
3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes; and
4. when provided on the written order of a Physician or health care practitioner, including the written order of a health care practitioner practicing under protocols jointly developed with a Physician:
   a. a diabetes self-management training program recognized by the American Diabetes Association;
   b. diabetes self-management training given by a multidisciplinary team:
      (1) the non-physician members of which are coordinated by:
         (i) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or

         (ii) a person who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;
      (2) that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and
      (3) each member of which, other than a social worker, has recent didactic and experimental preparation in diabetes clinical and educational issues as determined by the member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training;

c. diabetes self-management training provided by a diabetes educator certified by the National Certification Board for Diabetes Educators; or
d. diabetes self-management training in which one or more of the following components are provided:
   (1) the nutrition counseling component provided by a licensed dietitian, for which the licensed dietitian shall be paid;
   (2) the pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid;
   (3) any component of the training provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except that the physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or
   (4) any component of the training provided by a Physician.

Phenylketonuria Treatment Benefit: We will pay the Usual and Reasonable expenses incurred for formulas necessary to treat Phenylketonuria or a Heritable Disease.

Prosthetic and Orthotic Devices Benefit: We will pay the Usual and Reasonable expenses incurred for the most appropriate model of Prosthetic Device or Orthotic Device that adequately meets the medical needs of the Insured Person as determined by the Insured Person's treating Physician or podiatrist and prosthetist or orthotist, as applicable. The repair and replacement of a Prosthetic Device or Orthotic Device is a covered benefit unless the repair or replacement is necessitated by misuse or loss by the Insured Person.

Telehealth Services and Telemedicine Service Benefit: We will pay the Usual and Reasonable expenses incurred for for telehealth services and telemedicine medical services to the extent that they are Medically Necessary.

Inpatient Mastectomy and Reconstructive Surgery Benefit: We will pay the Usual and Reasonable expenses incurred for a mastectomy for inpatient care for a minimum of:
1. 48 hours following a mastectomy; and
2. 24 hours following a lymph node dissection for the treatment of breast cancer.

Related to the mastectomy, We will also pay the Usual and Reasonable expenses incurred for:
1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

Child Immunizations Benefit: When Dependent coverage is a part of this policy. We will pay the expenses incurred for childhood immunizations against:
1. diphtheria;
2. haernophilus influenza type b;
3. hepatitis B;
4. measles:
5. mumps:
6. pertussis: by law.
7. polio.
8. rubella:
9. tetanus;
10. varicella: and
11. any other immunization that is required for the child by law.

Benefits for such immunizations are not subject to any Deductible, Copayment, or Coinsurance requirements.

Hearing Test Benefit: When Dependent coverage is a part of this policy, we will pay the Usual and Reasonable expenses for the following, for each covered dependent child:
1. a screening test for hearing loss from birth through the date the child is 30 days of age; and
2. necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months of age.

Must Offers

Loss or Impairment of Speech and Hearing: We will pay the Usual and Reasonable expenses incurred for the Medically Necessary care and treatment of loss or impairment of speech or hearing. Benefits are provided on the same basis as any other Covered Sickness.

SECTION VI - EXCLUSIONS AND LIMITATIONS

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

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

- **International Students Only -** Eligible expenses within the Insured Person's Home Country or country of origin that would be payable or medical treatment that is available under any governmental or national health plan for which the Insured Person could be eligible.
- preventive medicines, serums or vaccines of any kind except as specifically provided under the Policy or considered a Preventive Service under Description 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 provided for Pediatric Dental Care.
- services or supplies in connection with eye examinations, eyeglasses or contact lenses except as specifically provided in the Schedule of Benefits.
- weak, strained or flat feet.
- surgical procedures in connection with infertility unless such infertility is a result of a Covered Injury or Covered Sickness.
- expenses covered under any Workers' Compensation, occupational benefits plan, mandatory automobile no-fault plan, public assistance program or government plan, except Medicaid.
- charges of an institution, health service or infirmary for whose services payment is not required in the absence of insurance or services provided by Student Health Fees.
- any expenses in excess of Usual and Reasonable charges.
- loss 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 participation in 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, intramural or club sports.
- loss resulting from playing, practicing, traveling to or from, or participating in, or conditioning for, any professional sport.
- treatment, services, supplies or facilities in a Hospital owned or operated by the Veterans Administration or a national government or any of its agencies, except when a charge is made which the Insured Person is required to pay.
- services that are duplicated when provided by both a certified nurse-midwife and a Physician.
- Elective Surgery or Treatment unless such coverage is otherwise specifically covered under the Policy.
- charges incurred for, acupuncture, heat treatment, diathermy, manipulation or massage, in any form, except to the extent provided in the Schedule of Benefits.
- expenses for weight increase or reduction, and hair growth or removal unless otherwise specifically covered under the Policy.
- expenses for radial keratotomy.

- racing or speed contests**,** skin diving or sky diving, mountaineering (where ropes or guides are customarily used), ultra-light aircraft, parasailing, sail planing, hang gliding, bungee jumping, travel in or on ATV's (all terrain or similar type vehicles) or other hazardous sport or hobby.
- 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). Plastic or Cosmetic Surgery does not include newborn congenital defects, reconstructive surgery incident to craniofacial abnormalities or a mastectomy.
- treatment to the teeth, including surgical extractions of teeth. This exclusion does not apply to the repair of Injuries caused by a Covered Injury to the limits shown in the Schedule of Benefits.

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

A. A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate policies are used to provide coordinated coverage for members of a group, the separate policies are considered parts of the same plan and there is no COB among those separate policies.

   (1) Plan includes: group and nongroup insurance policies, health insuring corporation ("HIC") policies, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care policies, such as skilled nursing care; medical benefits under group or individual automobile policies; and Medicare or any other federal governmental plan, as permitted by law.

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

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

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

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

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

   The following are examples of expenses that are not Allowable expenses:

   (1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

   (2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

   (3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

   (4) If a person is covered by one Plan that calculates its benefits or services on the basis of Usual and Reasonable fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's Policy permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

   (5) The amount of any benefit reduction by the Primary plan because an Insured Person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

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

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

ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

If benefits are payable to the estate of an Insured Person or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay such indemnity, up to an amount not exceeding $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.

In addition, We may pay benefits on behalf of a minor child who qualifies as a dependent of an Insured Person on the child's behalf to a person who is not an Insured Person if an order providing for the appointment of a possessory or managing conservator of the child has been issued by a court in this or another state. A person who is not a Covered Person is entitled to be paid benefits only if the person presents to Us, with the claim application:

1. written notice that the person is a possessory or managing conservator of the child on whose behalf the claim is made; and
2. a certified copy of a court order designating the person as possessory or managing conservator of the child or other evidence designated by rule of the Texas Commissioner of Insurance that the person is eligible for the benefits as this section provides.

Reimbursement to the Texas Department of Human Services: In the event that the cost of an Insured Person's care and/or services for which benefits are payable under the Policy is paid through a medical assistance program of the Texas Department of Human Services, such benefits will be paid to the said Department. Such payment will be made up to the actual amount of such Department's coverage, but not to exceed the amount of benefits due under the Policy.

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

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

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

SECTION VIII - ADDITIONAL PROVISIONS

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

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

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

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

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

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

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

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

SECTION IX – APPEALS PROCEDURE

For purposes of this Section, the following definitions apply:

Adverse Determination means a determination by a Utilization Review Agent that health care services provided or proposed to be provided to a patient are not medically necessary or are experimental or investigational.

Emergency Care means health care services provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the individual's condition, sickness, or injury is of such a nature that failure to get immediate medical care could:

- place the individual's health in serious jeopardy;
- result in serious impairment to bodily functions;
- result in serious dysfunction of a bodily organ or part;
- result in serious disfigurement; or
- for a pregnant woman, result in serious jeopardy to the health of the fetus.

Utilization Review includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Utilization Review Agent means the licensed entity that conducts Utilization Review under this Policy.

Retrospective Utilization Review means Utilization Review conducted after services have been provided to an Insured Person.

Time for Notice of Adverse Determination

In the event of an Adverse Determination, the Utilization Review Agent will notify the Insured Person or a person acting on behalf of the Insured Person and the Insured Person's provider of record. The notification will be mailed or otherwise transmitted not later than two working days after the date of the request for Utilization Review and all information necessary to complete the review is received by the Utilization Review Agent. The notice of Adverse Determination will include:

1. the principal reasons for the Adverse Determination;
2. the clinical basis for the Adverse Determination;
3. a description or the source of the screening criteria that were utilized as guidelines in making the determination; and
4. a description of the procedure for the complaint and appeal process, including:
    (a) notification to the Insured Person of the Insured Person's right to appeal an Adverse Determination to an independent review organization;
    (b) notification to the Insured Person of the procedures for appealing an Adverse Determination to an independent review organization; and
    (c) notification to an Insured Person who has a life-threatening condition of the Insured Person's right to an immediate review by an independent review organization and the procedures to obtain that review.

The notification of Adverse Determination shall be provided by the Utilization Review Agent:

1. within one working day by telephone or electronic transmission to the provider of record in the case of a patient who is hospitalized at the time of the Adverse Determination, to be followed by a letter notifying the patient and the provider of record of an Adverse Determination within three working days;
2. within three working days in writing to the provider of record and the patient if the patient is not hospitalized at the time of the Adverse Determination; or

3. within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no case to exceed one hour from notification when denying poststabilization care subsequent to Emergency Care as requested by a treating Doctor or provider. In such circumstances, notification shall be provided to the treating Doctor or health care provider.

Time for Notice of Adverse Determination for Retrospective Utilization Review

If a Retrospective Utilization Review is conducted, the Utilization Review Agent will provide notice of an Adverse Determination in writing to the provider of record and the Insured Person, but not later than 30 days after the date on which the claim is received. This period may be extended once by the Utilization Review Agent for a period not to exceed 15 days, if the Utilization Review Agent:

1. determines that an extension is necessary due to matters beyond the Utilization Review Agent's control; and
2. notifies the provider of record and the Insured Person before the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the Utilization Review Agent expects to make a determination.

If the extension is required because of the failure of the provider of record or the patient to submit information necessary to reach a determination on the request, the notice of extension must: (1) specifically describe the required information necessary to complete the request; and (2) give the provider of record and the patient at least 45 days from the date of receipt of the notice of extension to provide the specified information.

If the period for making the determination under this section is extended because of the failure of the provider of record or the patient to submit the information necessary to make the determination, the period for making the determination is tolled from the date on which the Utilization Review Agent sends the notification of the extension to the provider of record or the patient until the earlier of:

1. the date on which the provider of record or the patient responds to the request for additional information; or
2. the date by which the specified information was to have been submitted.

Internal Appeal Process

If an Insured Person files a complaint concerning dissatisfaction or disagreement with an Adverse Determination, it is considered an appeal of that Adverse Determination. The procedures for appeals are as follows:

1. An Insured Person, a person acting on behalf of the Insured Person, or the Insured Person's Doctor or health care provider may appeal the Adverse Determination orally or in writing;
2. The Utilization Review Agent shall send to the appealing party a letter acknowledging the appeal within five working days from receipt of the date of its receipt of the appeal. The letter must also include the items listed in this provision and a list of the documents that the appealing party must submit for review by Utilization Review Agent. When Utilization Review Agent receives an oral appeal of Adverse Determination, it shall send a one-page appeal form to the appealing party;
3. Appeal decisions shall be made by a physician, provided that, if the appeal is denied and within 10 working days the health care provider sets forth in writing good cause for having a particular type of a specialty provider review the case, the denial shall be reviewed by a health care provider in the same or similar specialty as typically manages the medical or dental condition, procedure, or treatment under discussion for review of the Adverse Determination, and that specialty review shall be completed within 15 working days of receipt of the request;
4. In addition to the written appeal, there is a method for an expedited appeal procedure for Emergency Care denials and denials of continued stays for hospitalized patients. This procedure consists of a review by a health care provider who has not previously reviewed the case and who is of the same or a similar specialty as typically manages the medical condition, procedure, or treatment under review. The time frame in which the appeal must be completed shall be based on the medical or dental immediacy of the condition, procedure, or treatment, but may not exceed one working day from the date all information necessary to complete the appeal is received;
5. After the Utilization Review Agent has sought review of the appeal of the Adverse Determination, it shall issue a response letter to the patient or a person acting on behalf of the patient, and the patient's Doctor or health care provider, explaining the resolution of the appeal; and
6. Written notification to the appealing party of the determination of the appeal will be made as soon as practical, but in no case later than the 30th calendar day after the date the Utilization Review Agent receives the appeal.

7. If the appeal is denied, the written notification shall include a clear and concise statement of:
    (a) the clinical basis for the appeal's denial;
    (b) the specialty of the physician or other health care provider making the denial; and
    (c) notice of the appealing party's right to seek review of the denial by an independent review organization and the procedures for obtaining that review.

Notwithstanding this provision, in a circumstance involving an Insured Person's life-threatening condition, the Insured Person is entitled to an immediate external review by an Independent Review Organization as provided below and is not required to comply with procedures for an internal review of the Utilization Review Agent's Adverse Determination.

If the Insured Person Disagrees with Our Internal Review Determination

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

1. File a complaint with the Texas Department of Insurance, P.O. Box 149104, Austin, TX 78714-9104; 1-800-578-4677; www.tdi.texas.gov/; or
2. Request from Us an external review when the adverse benefit determination involves an issue of Medical Necessity, appropriateness, health care setting or the level of care or effectiveness.

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

External Review Procedure

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

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

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

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

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

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

6. For an expedited review: the Insured Person may make a request for an expedited external review after receiving an adverse benefit determination if:
   a. The Insured's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person if treated after the time frame of an expedited internal review.
   b. The Insured Person's treating physician certifies that the adverse benefit determination involves a medical condition that could seriously jeopardize the life or health of the Insured Person, or would jeopardize the Insured Person's ability to regain maximum function, if treated after the time frame of a standard external review. or
   c. The final adverse benefit determination concerns an admission, availability of care, continued stay, or health care service for which the Insured Person received Emergency Services, but has not yet been discharged from a facility.

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

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

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

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

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

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

External Review of Denial of Experimental or Investigative Treatment

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

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

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

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

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

PREAUTHORIZATION AND MEDICAL MANAGEMENT RIDER

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

Preauthorization means the process of determining Medical Necessity before an Insured Person receives certain Treatments, services, or supplies. The Insured Person must notify Us and gain Our approval before the Insured Person receives any Treatment, service, or supply listed in this rider. Preauthorization is not required for Emergency Services.

Preauthorization Process
The Insured Person is responsible for notifying the claims administrator at the phone number found on the Insured Person's ID card to begin the Preauthorization process. For inpatient benefits or surgery, We must respond within 3 calendar days before Hospital Confinement or surgery.

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

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

Preauthorization Benefits will be paid for services based on Medical Necessity or appropriateness of care unless the Physician has materially misrepresented the proposed medical or health care service or has substantially failed to perform the proposed medical or health care service.

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

Our claims administrator will make the determination within twenty-four (24) hours for concurrent hospitalization care, or within one (1) hour for post-stabilization Treatment or for a life-threatening condition, after receipt of all necessary information for review. For non-urgent requests, Our claims administrator will make the determination within three (3) calendar days after receipt of all necessary information for review. Notice of an Adverse Determination made by Our claims administrator will be in writing and will include:

1. The reasons for the Adverse Determination including the clinical rationale, if any.
2. Instructions on how to initiate standard or urgent appeal.
3. Notice of the availability, upon request of the Insured Person or his or her designee, of the clinical review criteria relied upon to make the Adverse Determination. The notice will specify any additional information needed by Our claims administrator to reach a decision on an appeal.
4. A description of the Insured Person's right to an immediate review by an independent review organization for an Insured Person who has a life-threatening situation and of the procedures to obtain that review.
5. A description of the Insured Person's right to an immediate review by an independent review organization for an Insured Person who is denied Prescription Drugs or intravenous infusions, for which the Insured Person is receiving benefits under the Policy, and of the procedures to obtain that review.

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

The Insured Person should contact his or her Physician with questions about any Preauthorization status.

Medical Management

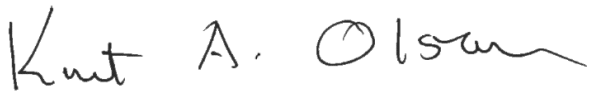
The benefits described in this Policy are subject to preauthorization, concurrent review, and discharge planning. The purpose of the reviews is to determine which services are Covered Medical Expenses and to assist in determining the most cost-effective methods of providing medical care. Such reviews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

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

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

All other provisions of the Policy remain unchanged.

NATIONAL GUARDIAN LIFE INSURANCE COMPANY



President

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

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

PRESCRIPTION DRUG RIDER

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

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

Prescription Drugs Retail Pharmacy Cost sharing does not apply to Affordable Care Act (ACA) Preventive Care prescriptions are filled at a participating network pharmacy.		
DESCRIPTION	**NETWORK**	**NON-NETWORK**
Retail		
Generic	100% of PPO Allowance for Covered Medical Expenses Copayment: $25.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $25.00
Preferred Brand Drug	100% of PPO Allowance for Covered Medical Expenses Copayment: $50.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $50.00
Brand-Name Drug	100% of PPO Allowance for Covered Medical Expenses Copayment: $75.00	60% of Usual and Reasonable Charge for Covered Medical Expenses Copayment: $75.00

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 amount the Insured Person will pay will not be more than the lesser of: the applicable Copayment, the allowable claim amount, or the amount the Insured Person would pay if purchasing without health benefits or discounts. 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 preauthorization.

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. Any additional prescription drug and OTC drug treatment regimens will be subject to the cost sharing in the Schedule of Benefits. For details on the current list of tobacco cessation prescription drugs and OTC drugs covered with no cost sharing during the two 90-day treatment regimens allowed, visit www.studentplanscenter.com or call 1-800-756-3702.

4. **All supplies, including Prescription Drugs, and equipment** benefits for the control of diabetes will be dispensed as written, including Brand-Name products, unless a substitution is approved by the Physician who issues the written order for the supplies or equipment.

5. **Prescription Eye Drop Refills** to treat a chronic eye disease or condition are covered provided that:
   a. The original prescription states that additional quantities of the eye drops are needed;
   b. The refill does not exceed the total quantity of dosage units authorized by the prescribing Physician on the original prescription, including refills; and
   c. The refill is dispensed on or before the last day of the prescribed dosage period and:
      1) Not earlier than the 21st day after the date a prescription for a 30-day supply of eye drops is dispensed;

2) Not earlier than the 42nd day after the date a prescription for a 60-day supply of eye drops is dispensed; or
3) Not earlier that the 63rd day after the date a prescription for a 90-day supply of eye drops is dispensed.

6. **Synchronization of Refills for Maintenance Prescription Drugs** applies only to a medication that:
   a. Is covered by the Policy;
   b. Meets the prior authorization criteria specifically applicable to the medication under the Policy on the date the request for synchronization is made;
   c. Is used for Treatment and management of a chronic illness;
   d. May be prescribed with refills;
   e. Is a formulation that can be effectively dispensed in accordance with the medication synchronization plan; and
   f. Is not a Schedule II controlled substance or a Schedule III controlled substance containing hydrocodone.

   We shall prorate any cost-sharing amount charged for a partial supply of a Prescription Drug, based on the number of days' supply of the drug actually dispensed, if:
   a. The pharmacy or the Insured Person's prescribing Physician notifies Us that:
      1) The quantity dispensed is to synchronize the dates that the pharmacy dispenses the Insured Person's Prescription Drugs; and
      2) The synchronization of the dates is in the best interest of the Insured Person; and
   b. The Insured Person agrees to the synchronization.

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.

   If We do not deny the override request with 72 hours after receiving it, the request is considered granted. If the prescribing Physician reasonably believes that the denial of the override request makes the death of or serious harm to the Insured Person probable, the request is considered granted if We do not deny the request before 24 hours after receiving the request. If We deny the request it is considered an Adverse Determination and is subject to an expedited review. A resolution of the expedited review may not exceed one working day from the date all information necessary to complete the review is received.

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.studentplanscenter.com or by calling 1-800-756-3702 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.

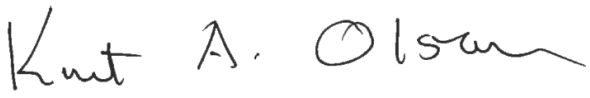
EXCLUSIONS

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, except for drugs used for controlling blood sugar levels;
- a drug which has an over-the-counter equivalent;
- Brand-Name Prescription Drugs with generic equivalents;
- weight control drugs;
- fertility drugs;
- vitamins, minerals, food supplements, except for formulas necessary to treat phenylketonuria or a heritable disease;
- sexual enhancements drugs;
- dietary supplements, except for formulas necessary to treat phenylketonuria or a heritable disease;
- 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

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

A Mutual Company Incorporated in 1909
PO Box 1191 • Madison, WI 53701-1191

POLICY AMENDMENT

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

The **DEFINITIONS** section is amended as described below.
The definition of Accident is deleted in its entirety and replaced with the following:
Accident means a sudden, unforeseeable external event which results independently of disease, bodily infirmity, or any other cause that causes Injury to an Insured Person.

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

The definition of Covered Sickness is deleted in its entirety and replaced with the following:
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.

The Definition of Nervous, Mental, or Emotional Disorder is deleted in its entirety and replaced with the following:
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.

The following new definitions are added.
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.

Telehealth Service means a health service, other than a Telehealth Medical Service, provided by a health professional who is licensed, certified or otherwise entitled to practice in Texas and acting within the scope of his or her license, certification or entitlement to an Insured Person at a different physical location than the health care professional.

Telemedicine Medical Service means a health care service provided by a Physician to an Insured Person at a different physical location than the Physician through use of telecommunications or information technology.

The **DESCRIPTION OF BENEFITS** section is amended as described below.
Inpatient Benefits
The benefit called Nervous, Mental, or Emotional Disorders Treatment Expense is deleted in its entirety. It is replaced with:
8. 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.

The Substance Use Disorder Benefit below is added.
10. 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
The benefit called Nervous, Mental, or Emotional Disorders Treatment Expense is deleted in its entirety. It is replaced with:

9. 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.

The Substance Use Disorder Benefit below is added.

14. 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
The **Substance Abuse Disorder Benefit** is deleted in its entirety**.**

The **Hearing Aid Benefit** is deleted in its entirety. It is replaced with:
Hearing Aid or Cochlear Implant: We will pay for the following services and supplies for an Insured Person who is age 18 or younger:

1. fitting and dispensing services and ear molds as necessary to allow optimal fit of hearing aids;
2. treatment related to hearing aids and cochlear implants, including habilitation and rehabilitation necessary for educational gain; and
3. for a cochlear implant, an external speech processor and controller, with replacement of necessary components every three years.

Coverage is limited to one hearing aid in each ear every three years and one cochlear implant in each ear with internal replacement as medically and audiologically necessary. This benefit is subject to any Coinsurance, Copayment, and Deductible shown in the Schedule of Benefits.

Mandated Benefits for Texas

Low-Dose Mammography: We will pay for an annual low-dose mammogram, including Breast Tomosynthesis, for a female Insured Person who is age 35 or older. The Affordable Care Act Preventive Service mammography benefit does not include Low-Dose Mammography. This benefit is subject to any Coinsurance, Copayment, and Deductible shown in the Schedule of Benefits.
As used in this benefit:
Breast Tomosynthesis means a type of mammography where a low-dose x-ray system and computer reconstructions to create three-dimensional images of breasts.

This Rider takes effect with and expires on the same date as the Policy to which it is attached.

There are no other changes to the Policy or Certificate.

In witness whereof We have caused this Rider to be signed by Our President and Secretary.

Kimberly A. Shaul, Secretary

Knut A. Olson, President

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

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

Why We Collect and How We Use Information:

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

Types of Information We Collect:

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

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

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

We also may keep Information about your transactions with us:

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

Additional Information is received from:

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

How We Disclose Your Information:

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

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

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

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

Access to and Correction of Your Information:

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

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

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

How We Protect Your Information:

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

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

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

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

National Guardian Life Insurance Company
Commercial Travelers Life Insurance Company

JOINT NOTICE OF PRIVACY PRACTICES

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

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

How We May Use or Disclose Your Health Information

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

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

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

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

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

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

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

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

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

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

When We May Not Use or Disclose Your Health Information

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

Statement of Your Health Information Rights

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

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

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

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

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

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

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

Our Obligations Under This Notice

We are required by law to:

1. Maintain the privacy of your health information.

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

3. Abide by the terms of this Notice.

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

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

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

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

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

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

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

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

Effective Date of This Notice: June 12, 2017

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION
(For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association Law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met
  1) The policyholder has a policy with a company domiciled in Texas;
  2) The policyholder's state of residence has a similar guaranty association; and
  3) The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, and $200,000 for other types of health insurance.

Life Insurance

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life.

Group Annuities

- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information:

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov

COMPLAINT NOTICE

IMPORTANT NOTICE

To obtain information or to make a complaint:

You may call National Guardian Life Insurance Company's toll-free telephone number for information or to make a complaint at:

1-800-756-3702

You may also write to National Guardian Life Insurance Company at:

c/o Commercial Travelers Life Insurance Company
70 Genesee Street, Utica, NY 13502

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance:

P.O. Box 149104
Austin, TX 78714-9104

Fax: (512) 490-1007

Web: www.tdi.texas.gov

E-Mail: ConsumerProtection@tdi.texas.gov

PREMIUM OR CLAIM DISPUTES:

Should you have a dispute concerning your premium or about a claim, you should contact the agent first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY:

This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de National Guardian Life para obtener informacion o para presentar una queja al:

1-800-756-3702

Usted tambien puede escribir a la oficina National Guardian Life Insurance Company:

c/o Commercial Travelers Life Insurance Company
70 Genesee Street, Utica, NY 13502

Usted puede comunicarse con el Departamento de Seguros de Texas para obtener informacion sobre companias, coberturas, derechos, o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas a:

P.O. Box 149104
Austin, TX 78714-9104

FAX: (512) 490-1007

Sitio: www.tdi.texas.gov

E-Mail: ConsumerProtection@tdi.texas.gov

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMACIONES: Si tiene una disputa relacionada con su prima de seguro o con una reclamacion, usted debe comunicarse con el agente primero. Si la disputa no es resuelta, usted puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE AVISO A SU POLIZA: Este aviso es solamente para propositos informativos y no se convierte en parte o en condicion del documento adjunto.

National Guardian Life Insurance Company
It's about people.

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

APPLICATION FOR STUDENT BLANKET ACCIDENT AND SICKNESS INSURANCE

1. Name of School, College or University: Southern Methodist University

   Address: Dallas, TX

2. Plan of Benefits:

   ❑ Same as current year's program, except _____

   ❑ In accordance with proposal dated _____, 20_____

   ☒ Other In accordance with Policy No. 2019A4A24-01 et al and all attachments hereto.

3. Premium Rates:

	Annual
Student:	$2,978.00
Spouse:	$2,978.00
Child(ren):	$2,978.00

4. Terms of coverage, from: August 1, 2019 To: August 1, 2020

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: _____

National Guardian Life Insurance Company
It's about people.

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

APPLICATION FOR STUDENT BLANKET ACCIDENT AND SICKNESS INSURANCE

1. Name of School, College or University: Southern Methodist University

   Address: Dallas, TX

2. Plan of Benefits:

   ❑ Same as current year's program, except _____

   ❑ In accordance with proposal dated _____, 20_____

   ☒ Other In accordance with Policy No. 2019A4A24-02 et al and all attachments hereto.

3. Premium Rates:

	Annual
Student:	$2,978.00
Spouse:	$2,978.00
Child(ren):	$2,978.00

4. Terms of coverage, from: September 9, 2019 To: September 9, 2020

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: _____